

28730

3977

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>PG.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cheverly</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Washington D.C.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince George General Hospital</u>		STREET ADDRESS (If rural, give location) <u>3619 Eastern Ave. N.E.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Aaron</u> (Middle) <u>JEANNE</u> (Last) <u>Anita</u>	4. DATE OF DEATH	(Month) <u>April</u> (Day) <u>21</u> (Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>June 28, 1950</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>19</u> yrs. <u>19</u> months <u>23</u> days
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Albert Aaron</u>		14. MOTHER'S MAIDEN NAME <u>Marian</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	
(If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Albert Aaron - Same</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Septicemia</u>		<u>Sexual</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Diarrhea</u>		<u>1 wk</u>
	(c) <u>Dehydration & malnutrition</u>		<u>1 wk</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/18, 1951, to 4/21, 1951, that I last saw the deceased alive on 4/21, 1951, and that death occurred at 2:10 p.m., from the causes and on the date stated above.

SIGNATURE Thomas A. Krustevski M.D. ADDRESS College Park, Ind. DATE SIGNED 4/21/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>4-23-51</u>	<u>St. Carmel</u>	<u>Balto Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>4/23/51</u>	<u>A. W. Hedrick</u>	<u>Frank Lewis</u>	<u>2100 Eastern Pk</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

3976

Reg. Dist. No. 100

1. PLACE OF DEATH - COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Pr Geo</u>	
CITY (If outside corporate limits, write nearest town) <u>Brandywine Md</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine Md</u>	
TOWN <u>Brandywine Md</u>		TOWN <u>Brandywine Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Popular Hill Road</u>		STREET ADDRESS (If rural, give location) <u>Popular Hill Road</u>	
3. NAME OF DECEASED (First) <u>John McNeil</u> (Middle) <u>Adam</u> (Last) <u>s</u>		4. DATE OF DEATH (Month) <u>Apr</u> (Day) <u>29</u> (Year) <u>1957</u>	
5. SEX <u>MC</u>	6. COLOR OR RACE <u>negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>married</u>	8. DATE OF BIRTH <u>Apr 29 1898</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>renter</u>	9. AGE last birthday <u>52</u> yrs. If under 1 year Months <u>0</u> Days <u>0</u> If under 24 hours Hours <u>0</u> Min. <u>0</u>
11. BIRTHPLACE (State or foreign country) <u>Aquasco Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Thomas Adams</u>		14. MOTHER'S MAIDEN NAME <u>Ruby Glasgow</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>unknown</u>	
17. INFORMANT AND ADDRESS <u>Gertrude Rose Adams</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH <u>20 min.</u>
Immediate cause (a) <u>Acute coronary occlusion</u> Antecedent cause(s) (b) <u>General arteriosclerosis</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>420.1 94a</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>—</u>			
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>none</u>		PLACE (Home, farm, factory, street, OF office, bldg., etc.) <u>Home</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>no injury</u> m.		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
		HOW DID INJURY OCCUR? <u>Died sitting in a chair.</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>Paul E. Van Gath</u> (Degree or title) <u>Asst. Coroner</u>		ADDRESS <u>Washington 1900</u> DATE SIGNED <u>Apr 30 1957</u>	
23. BURIAL, CREMATION OR REMOVAL (Specify) <u>—</u>		DATE THEREOF <u>May 2 1957</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Thomas</u>		LOCATION (City, town, or county) <u>Aquasco Md</u> (State) <u>Md</u>	
DATE REC'D BY LOCAL REG. <u>4/30/57</u>		REGISTRAR'S SIGNATURE <u>John H. H. H.</u>	
24. FUNERAL DIRECTOR <u>Thurman H. H. H.</u>		ADDRESS <u>—</u>	

100/105

RECEIVED
JUL 3 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

3978

Reg. Dist. No. 242

1. PLACE OF DEATH- COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE District of Columbia	
CITY (If outside corporate limits, write RURAL and give nearest town) Forestville		CITY (If outside corporate limits, write RURAL and give nearest town) Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3rd St and Marlboro Pike		STREET ADDRESS (If rural, give location) 1725 34th Street N. W.	
3. NAME OF DECEASED (First) (Middle) (Last) Prudence Adams		4. DATE OF DEATH (Month) (Day) (Year) 4 22 1951	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, Single	8. DATE OF BIRTH 7/8/35
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		9b. KIND OF BUSINESS OR INDUSTRY School	9. AGE last birthday 15 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		11. BIRTHPLACE (State or foreign country) Norwich, Conn.	
13. FATHER'S NAME Quincey Adams		14. MOTHER'S MAIDEN NAME Luolie Ethel Thornton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS Mrs Thomas Lee Smith		12. CITIZEN OF WHAT COUNTRY USA	

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
(a) Immediate cause Hemorrhage and shock (b) Antecedent cause(s) Crushed skull Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office, etc.) at place of death
(CITY OR TOWN) (COUNTY) (STATE) Forestville P. G. Md	
TIME (Month) (Day) (Year) (Hour) 4 22 51 2A.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>
HOW DID INJURY OCCUR? Occupant of car that struck fixed object	

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE **James H. Boyd** M. D. **Forestville, Md.** DATE SIGNED **4/22/51**

3. BURIAL, CREMATION, REMOVAL (Specify) **Removal** DATE THEREOF **4/22/51** NAME OF CEMETERY OR CREMATORY **Cawler Funeral Home** LOCATION (City, town, or county) (State) **Washington D.C.**

DATE REC'D BY LOCAL REG **4/22/51** REGISTRAR'S SIGNATURE **Carrie F. Campbell.** 24. FUNERAL DIRECTOR **E. Gasche, son of Fatherville, Md.** ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 30 1951
BUREAU V. S.

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 242

1. PLACE OF DEATH- COUNTY <u>Prince Georges</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>SEAT PLEASANT</u> LENGTH OF STAY (in, this place) <u>LIFE</u> TOWN <u>SEAT PLEASANT</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7205 F ST. N.E.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Prince Georges Co</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>SEAT PLEASANT</u> TOWN <u>SEAT PLEASANT</u> STREET ADDRESS (If rural, give location) <u>7205-F ST N.E.</u>	
3. NAME OF DECEASED (First) <u>Maurice</u> (Middle) <u>ZENIC</u> (Last) <u>Aisquith</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>27</u> (Year) <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>10-11-09</u>
9. AGE last birthday <u>41</u> yrs.	10. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CAB DRIVER</u> b. KIND OF BUSINESS OR INDUSTRY <u>TAXI DRIVER</u>		
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Nelson Aisquith</u>		14. MOTHER'S MAIDEN NAME <u>DOVE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>577-03-9318</u>	
17. INFORMANT AND ADDRESS <u>ELISIE R. AISQUITH - 7205 F ST. N.E. - SEAT PLEASANT, MD</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Acute coronary occlusion</u>		<u>30 min</u>
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>General arteriosclerosis</u>		<u>about 1 year</u>
131a (c) <u>and Cardiovascular degeneration</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION <u>none</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> <u>Natural causes</u>	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>no injury</u>	(CITY OR TOWN) _____ (COUNTY) _____ (STATE) _____
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>none</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>none</u>

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ or Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4-30-57</u>	NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	LOCATION (City, town, or county) <u>Prince Georges Co Md.</u>
DATE REC'D BY LOCAL REG. <u>Apr. 28-57</u>	REGISTRAR'S SIGNATURE <u>Carrie F. Campbell</u>	24. FUNERAL DIRECTOR <u>W. W. Chambers Co</u>	ADDRESS <u>577-H ST. N.E.</u>

682536

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

RECEIVED
APR 30 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

3980

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 245

1. PLACE OF DEATH COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Prince Georges	
CITY (If outside corporate limits, write RURAL and give nearest town) W. Hyattsville		CITY (If outside corporate limits, write RURAL and give nearest town) W. Hyattsville	
TOWN W. Hyattsville		TOWN W. Hyattsville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5722-30th Ave		STREET ADDRESS (If rural, give location) 5722-30th Ave	
3. NAME OF DECEASED (Type or Print)	(First) Doris	(Middle) Berghold	(Last) Alderton
4. DATE OF DEATH	(Month) 4	(Day) 1	(Year) 1957
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH June 18, 1904
9. AGE last birthday 46 yrs.		10. AGE last birthday 46 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book-keeper		10b. KIND OF BUSINESS OR INDUSTRY Commerce Dept.	
11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Maybury		14. MOTHER'S MAIDEN NAME Bertha F. Hayden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT James B. Alderton, Husband			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a)

Doxemia

Antecedent cause(s)

(b)

Cirrhosis of liver

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(c)

Cardiovascular renal disease

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. EXTERNAL CAUSE WAS

PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION OR REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

4/3/57

Mrs. Jas. Devereaux (Deputy)

F. Gasch's Sons

Hyattsville Maryland

310 916

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

3981

Reg. Dist. No. 232

1. PLACE OF DEATH: COUNTY <u>PRINCE GEORGES'</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>NEW JERSEY</u> COUNTY <u>ATLANTIC</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL T.B.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>ATLANTIC CITY</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>248 NEVADA AVENUE</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>JOYCE</u>	(Middle) <u>MARTHA</u>	(Last) <u>ALLEN</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>10/11/31</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>	9. AGE last birthday <u>19</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>NEW JERSEY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>G.W. KUMMEL</u>		14. MOTHER'S MAIDEN NAME <u>RAYMOND</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No.	
17. INFORMANT <u>MR. G.W. KUMMEL</u>		<u>248 NEVADA AVE. ATLANTIC CITY, N.J.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>
8/16.5 Immediate cause <u>Crushed chest fractured upper left ribs, lateral femoral neck and shock. following auto accident.</u>		
1700 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>none</u>		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>	
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19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION <u>none</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
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21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING	PLACE (Home, farm, factory, street, or office bldg, etc.) <u>Highway 301 near T.B.</u>	(CITY OR TOWN) <u>T.B. Prince George Co</u>	(COUNTY) <u>md.</u>	(STATE) <u>md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>April 8 1951 3 P.m.</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Auto crashed into door of victim car.</u>		

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE <u>Samuel M. Smith M.D. Act. Dist. Comm. Washington 1906</u>		DATE SIGNED <u>Apr 9 1951</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	DATE THEREOF <u>April 9 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Ritchie Brec.</u>	LOCATION (City, town, or county) (State) <u>Atlantic City N.J.</u>
24. FUNERAL DIRECTOR <u>Ritchie Brec.</u>		ADDRESS <u>Upper Marlboro, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 10 1951
BUREAU V. A.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. **234**

3982

234

234

1. PLACE OF DEATH- COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE _____ COUNTY _____	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fort Belvoir</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
TOWN _____		TOWN _____	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Potomac River</u>		STREET ADDRESS <u>719-G Street, S.W.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>William Barker Barnes</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>4 11 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 15, 1906</u>
9. AGE last birthday <u>44</u> yrs.		10. If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wood finisher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James E. Barnes</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Allen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>W.W. 2</u>	
17. INFORMANT <u>Catherine Mary Barnes</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>Asphyxia</u>		
(b) Antecedent cause(s) <u>Drowning</u>		
173 • Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Airplane crashed into Potomac River</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION <u>4-7-51</u>	19b. MAJOR FINDINGS OF OPERATION <u>5.00</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office, etc.) OF INJURY <u>Potomac River</u>	(CITY OR TOWN) (COUNTY) (STATE) <u>Fort Belvoir, Prince Georges, Md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>4-7-51 5.00</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Passenger in airplane which crashed into Potomac River</u>

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE <u>John W. Maloney, M.D.</u>	(Degree or title) <u>Dep. Med. Exam.</u>	ADDRESS <u>Cheverly, Md.</u>	DATE SIGNED <u>4-11-51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Buried</u>	DATE THEREOF <u>13 April 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>	LOCATION (City, town, or county) (State) <u>Washington, Va.</u>
DATE REC'D BY LOCAL REG. <u>4/11/51</u>	REGISTRAR'S SIGNATURE <u>Max Alton Davis</u>	24. FUNERAL DIRECTOR <u>Robt. A. Mattingly</u>	ADDRESS <u>Washington, D.C.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REC.

RECEIVED
APR 29 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

3983

1. PLACE OF DEATH COUNTY <u>Prince George's</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Prince Geo's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Colmar Manor</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Colmar Manor</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>((residence) 4103 Newton Street</u>		STREET ADDRESS <u>4103 Newton Street</u>	
3. NAME OF DECEASED (Type or Print) <u>MARY MAGDALENE BARROWS</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>1st.</u> (Year) <u>19 51</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Jan 19 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	9. AGE last birthday <u>72</u> yrs.
13. FATHER'S NAME <u>Christian Muth</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
		17. INFORMANT AND ADDRESS <u>Mr. Leonard J. Fastnaught 4103 Newton St. Colmar Manor, Md.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>6 1/2 weeks</u>
420.0 Immediate cause (a) <u>myocardial infarction</u>		
93d Antecedent cause(s) (b) <u>arteriosclerotic Heart Disease</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>chronic cholecystitis</u>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 12, 1951, to March 31, 1951, that I last saw the deceased alive on March 31, 1951, and that death occurred at 4:00 a.m., from the causes and on the date stated above.

SIGNATURE Jackson T. Marland M.D. (Degree or title) ADDRESS 1818 C S.E. April 1, 1951 DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE <u>April 3 1951</u>	NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>	LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
DATE REC'D BY LOCAL REG. <u>April 2</u>	REGISTRAR'S SIGNATURE <u>Amanda Downey</u>	24. FUNERAL DIRECTOR <u>W.W. Chambers CO.</u>	ADDRESS <u>5801 Cleveland Ave. Riverdale, Md.</u>

1951

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 4 1951
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

3984

1. PLACE OF DEATH COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY Prince Geo.	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Cheverly		LENGTH OF STAY (in this place) 3 days		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Hyattsville,	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Prince Georges General Hospital				STREET ADDRESS (If rural, give location) 4229 Madison Street,	
3. NAME OF DECEASED (Type or Print)		(First) Kathleen		(Middle) Marie	
		(Last) Bell		4. DATE OF DEATH (Month) Apr. (Day) 30. (Year) 1951	
5. SEX female	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH 4/27/51	9. AGE last birthday yrs. 3	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME William J. Bell		14. MOTHER'S MAIDEN NAME Marion Kreckel		12. CITIZEN OF WHAT COUNTRY U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY No. NONE		17. INFORMANT AND ADDRESS Mrs. William J. Bell 4229 Madison St.,	

18. MEDICAL CERTIFICATION Hyattsville, Md.				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause (a) Atelectasis (multiple, bilaterally) due to aspiration of foreign body (formula) with apnoea.					
Antecedent cause(s) (b) 1951d giving rise to the above cause stating the underlying cause last acute cardiac failure.					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 4/27, 1951, to 4/30/1951, that I last saw the deceased alive on 4/29/1951, and that death occurred at 9:00 a. m., from the causes and on the date stated above.					
SIGNATURE Donald S. Fletcher M.D.		(Degree or title)		ADDRESS 5432 Queens Chapel Rd Hyattsville Md 4/30/51	
DATE SIGNED		23. BURIAL, CREMATION OR TOWAL (Specify) Burial		DATE THEREOF May 14, 1951	
		NAME OF CEMETERY OR CREMATORY FORT LINCOLN Cem.		LOCATION (City, town, or county) (State) Colmar Manor Md (B.G.)	
DATE REC'D BY LOCAL REG 4/30/51		REGISTRAR'S SIGNATURE Amanda Downey		24. FUNERAL DIRECTOR W.W. CHAMBERS Co - Riverdale Md	

204271374405

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 3 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 3985

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mt Rainier</u>	
TOWN <u>Cherry</u>		TOWN <u>Mt Rainier</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince Georges Hosp</u>		STREET ADDRESS (If rural, give location) <u>3104 Taylor Street</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Edith</u> (Middle) <u>-</u> (Last) <u>Bennett</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>16</u> (Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>m</u>	8. DATE OF BIRTH <u>Oct. 15, 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	9. AGE last birthday <u>71</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amr</u>	
13. FATHER'S NAME <u>Smith Rhodes</u>		14. MOTHER'S MAIDEN NAME <u>Whitehead</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>W</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Lily Caracas Silver Springs Md</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Hypostatic Pneumonia</u>		<u>4 days</u>
Antecedent cause(s) (b) <u>Cerebro-vascular accident - right side</u>		<u>9 days</u>
(c) <u>Arteriosclerosis</u>		<u>years</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/7, 1951, to 4/16, 1951; that I last saw the deceased alive on 4/16, 1951, and that death occurred at 7:10 p.m., from the causes and on the date stated above.

SIGNATURE Russell V. Fletcher Jr ADDRESS 1432 Annapolis Rd. Hyattsville Md DATE SIGNED 4/16/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4/19/51</u>	NAME OF CEMETERY OR CREMATORY <u>St Lincoln</u>	LOCATION (City, town, or county) (State) <u>Colmar Manor Md</u>
DATE REC'D BY LOCAL REG <u>4/18/51</u>	REGISTRAR'S SIGNATURE <u>Amanda Downey</u>	24. FUNERAL DIRECTOR <u>Fletcher sons Hyattsville Md</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 20 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

3986

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>University Park</u>	
TOWN <u>2 days</u>		TOWN <u>University Park</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince Georges Gen. Hosp</u>		STREET ADDRESS (If rural, give location) <u>4409-Tueckerman St.</u>	
3. NAME OF DECEASED (First) <u>EMMA</u>	(Middle)	(Last) <u>BROWN</u>	4. DATE OF DEATH (Month) <u>April</u> (Day) <u>21</u> (Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>29 Nov. 1861</u>
9. AGE last birthday <u>89</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Lancaster</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Selvey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Florence Childs University Park</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cerebral vascular accident

INTERVAL BETWEEN ONSET AND DEATH

2 1/2 hrs.

Antecedent cause(s)

(b)

Hypertensive constrictive - myocardial disease

8 yrs.

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-19, 1951, to 4-21, 1951, that I last saw the deceased

alive on 4-20, 1951, and that death occurred at 6:15 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

4/22/51

Amanda Daumy

J. Basche sons & daughter Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

APR 24 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

3987

Reg. Dist. No. *145*

1. PLACE OF DEATH - COUNTY <i>Prince Georges</i>		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <i>Maryland</i> COUNTY <i>Prince Georges</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>College Park</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>College Park</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>4607 College Ave</i>		STREET ADDRESS (If rural give location) <i>4607 College Ave</i>	
3. NAME OF DECEASED (First) <i>Josephine</i>	(Middle) <i>Brunck</i>	(Last) <i>Brunck</i>	4. DATE OF DEATH (Month) <i>Apr.</i> (Day) <i>30</i> (Year) <i>1957</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <i>Single</i>	8. DATE OF BIRTH <i>Feb. 26, 1925</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <i>26</i> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William R. Brunck</i>		14. MOTHER'S MAIDEN NAME <i>Mildred Mason</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
		17. INFORMANT <i>William Brunck - Father</i>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <i>Broncho pneumonia</i>		
Antecedent cause(s) (b) <i>Gentle encephalitis</i>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>Chicken pox.</i>		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>May 2, 1957</i>	NAME OF CEMETERY OR CREMATORY <i>St. Lincoln</i>	LOCATION (City, town, or county) (State) <i>Colmar Manor Md 4-30-57</i>
DATE REC'D BY LOCAL REG. <i>May 2, 1957</i>	REGISTRAR'S SIGNATURE <i>James Severy</i>	24. FUNERAL DIRECTOR <i>Charles Sam Hyattsville Md</i>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 4 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3988

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH - COUNTY <u>PRINCE GEORGE MARYLAND</u>		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>MARYLAND</u> COUNTY <u>PRINCE GEORGE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON 1920</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON 1920</u>	
TOWN <u>WASHINGTON 1920</u>		TOWN <u>WASHINGTON 1920</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>301 MAURY AVE. S.E.</u>		STREET ADDRESS (If rural, give location) <u>301 MAURY AVE S.E.</u>	
3. NAME OF DECEASED (First) <u>ROBERT</u> (Middle) <u>EDWARD</u> (Last) <u>CANTER</u>		4. DATE OF DEATH (Month) <u>APR</u> (Day) <u>27</u> (Year) <u>1951</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>FEB-18-1895</u>
9. AGE last birthday <u>56</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>HUGHESVILLE, Md</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER owner</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LUKE CANTER</u>		14. MOTHER'S MAIDEN NAME <u>ANNA Goldsmith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY No. <u>3</u>	
17. INFORMANT AND ADDRESS <u>MRS NELLIE MAURY, Hughesville, Md</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

446x Immediate cause

Antecedent cause(s)

13/a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from April 1, 1951, to April 27, 1951, that I last saw the deceased alive on April 24, 1951, and that death occurred at 5:45 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE <u>4/30/51</u>	NAME OF CEMETERY OR CREMATORY <u>Old Field</u>	LOCATION (City, town, or county) <u>Hughesville 9nd</u>
DATE REC'D BY LOCAL REG. <u>Apr. 27, 51</u>	REGISTRAR'S SIGNATURE <u>Carrie F. Campbell</u>	24. FUNERAL DIRECTOR <u>W. W. Chambers Co. 517 N. St. SE</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

100105 oc

RECEIVED
APR 30 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Prince George</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fort Pleasant</u>	
TOWN <u>Prince Georges Gen Hosp</u>		TOWN <u>Box 5404</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Charles</u> (First) <u>Cassidy</u> (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>April 23 1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>?</u>
9. AGE last birthday <u>80?</u> yrs.		10. DATE OF BIRTH	
11. BIRTHPLACE (State or foreign country) <u>unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>unknown</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Dr. Records</u>			

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
(a) <u>arteriosclerotic cordis meatus - renal</u>	
(b) <u>diarrhea</u>	
(c) <u>malnutrition - dehydration</u>	
II. OTHER SIGNIFICANT CONDITIONS	
Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 4-18, 1951, to 4-23, 1951, that I last saw the deceased alive on 4-22, 1951, and that death occurred at 5:00 m., from the causes and on the date stated above.

SIGNATURE <u>R. A. Sauer MD.</u> (Degree or title) <u>M.D.</u>		ADDRESS <u>4314 Baltimore St. Kemptville Md.</u>		DATE SIGNED <u>4-23-51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>burial</u>		DATE THEREOF <u>4/26/51</u>		NAME OF CEMETERY OR CREMATORY <u>Mount Mt School</u>	
LOCATION (City, town, or county) <u>Baltimore, Md</u>		(State) <u>Md</u>			
DATE REC'D BY LOCAL REG. <u>4/25/51</u>		REGISTRAR'S SIGNATURE <u>Amanda Sauer</u>		24. FUNERAL DIRECTOR <u>Frances A. Bensley 5781 Bridge St</u>	
				ADDRESS <u>100105</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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APR 27 1951

BUREAU V. S.

Reg. Dist. No. 231

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	May 1, 1951	510 Washington	Hyattsville Md.	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
5/1/51	Amanda Downey	E. Buschisms	Hyattsville Md.	

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 39911 31 45

1. PLACE OF DEATH COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>ARDMORE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ARDMORE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>ARDMORE RD.</u>		STREET ADDRESS (If rural, give location) <u>ARDMORE RD.</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>HILDA INHOT</u>	<u>COOMES</u>		
6. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>4/15/1864</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>87</u> yrs.	4. DATE OF DEATH (Month) (Day) (Year) <u>April 21 1951</u>
11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>	12. CITIZEN OF WHAT COUNTRY? <u>US</u>	13. FATHER'S NAME <u>FREDERICK W. INHOT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>MR J. RAYMOND COOMES - ARDMORE, MD.</u>		18. MOTHER'S MAIDEN NAME <u>CAROLINE SCHNEIDER</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>myocarditis</u>		<u>6 mos</u>
Antecedent cause(s) (b) <u>422.2</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>93e</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/20/51 to 4/21/51, that I last saw the deceased alive on 4/20/51 and that death occurred at 3:20 PM, from the causes and on the date stated above.

SIGNATURE <u>Leonard Hays</u>	(Degree or title)	ADDRESS <u>Hyattsville Md 4-21-51</u>	DATE SIGNED
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4/23/51</u>	NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cem.</u>	LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>
DATE REC'D BY LOCAL REG. <u>April 23 1951</u>	REGISTRAR'S SIGNATURE <u>Amanda Downey</u>	24. FUNERAL DIRECTOR <u>Jos. Gawler's Sons, 1756 Pa. Ave N.W.</u>	ADDRESS <u>Washington, D. C.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MAY 7 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

3992

1. PLACE OF DEATH COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY pr. Geo.	
CITY (If outside corporate limits, write RURAL and give nearest town) Cheverly		CITY (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant,	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Prince Georges General Hospital		STREET ADDRESS (If rural, give location) 6910 George Palmer Highway,	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) (Middle) (Last) Davis		(Month) (Day) (Year) April 12, 1951	
5. SEX female	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 4/12/51
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 3 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Elliott Evans Davis		14. MOTHER'S MAIDEN NAME Florence Shearer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Mrs. Florence Davis - Address above			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **Latent Lues**

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work Not While At work

HOW DID INJURY OCCUR?

20. AUTOPSY?

Yes ☐ No ☐

22. I hereby certify that I attended the deceased from **4/12**, 19**51**, to **4/12**, 19**51**, that I last saw the deceased

alive on **4/12**, 19**51**, and that death occurred at **4/12**, 19**51**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG. **4/18/51**

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

204121273180

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APR 20 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 542

1. PLACE OF DEATH: COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cheltham</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cheltham</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) <u>Barbara</u> (Middle) <u>Jean</u> (Last) <u>DENT</u>	4. DATE OF DEATH (Month) <u>April</u> (Day) <u>28</u> (Year) <u>1951</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>INFANT</u>	8. DATE OF BIRTH <u>Jan. 19, 1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INFANT</u>	9. AGE last birthday <u>3</u> yrs. <u>9</u> months <u>9</u> days <u>9</u> hours <u>9</u> min.
11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Bernard Hawkins</u>		14. MOTHER'S MAIDEN NAME <u>Lucille Dent</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Lucille Dent</u>			

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
759.3 Immediate cause (a) <u>Cardiorespiratory Collapse due to</u>			<u>3 mos 9 day</u>
64 Antecedent cause(s) (b) <u>Enlarged Thymus gland due to</u>			
(c) <u>Birth anomaly</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>			
19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at <u>Work</u> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Feb</u> , 19 <u>51</u> , to <u>April</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>April 28</u> , 19 <u>51</u> , and that death occurred at <u>10 A.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Alfred R. Lapan M.D.</u>		DATE SIGNED <u>April 30, 1951</u>	
23. BURIAL CREMATION (REMOVAL) (Specify) <u>Burial</u>	DATE THEREOF <u>5-1-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
DATE REC'D BY LOCAL REG. <u>Apr. 30-51</u>	REGISTRAR'S SIGNATURE <u>Carrie F. Campbell</u>	24. FUNERAL DIRECTOR <u>Henry S. Washington & Sons</u>	ADDRESS <u>467 N. ST. N.W.</u>

RECEIVED
MAY 3 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 242

1. PLACE OF DEATH COUNTY <u>PRINCE GEORGE</u> MARYLAND CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>FORESTVILLE, MD</u> TOWN <u>11-MONTHS</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5450 PUMPHREY DR. S.E.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>PR. GEO.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON 19, D.C.</u> TOWN <u>WASHINGTON 19, D.C.</u> STREET ADDRESS (If rural, give location) <u>5450 PUMPHREY DR. S.E.</u>	
3. NAME OF DECEASED (Type or Print) <u>JOSEPH</u> (First) <u>H.</u> (Middle) <u>DOUGLAS</u> (Last) 4. DATE OF DEATH <u>APRIL 2</u> (Month) <u>1951</u> (Day) (Year)		5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u> 8. DATE OF BIRTH <u>MAY 11, 1874</u> 9. AGE last birthday <u>76</u> yrs. 10. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u> 11. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Steamfitter</u> 13. FATHER'S NAME <u>JOSEPH HARVEY DOUGLAS</u> 14. MOTHER'S MAIDEN NAME <u>ANN UPTON</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> 16. SOCIAL SECURITY No. <u>CLIFTON S. EUSEBIO</u> 17. INFORMANT <u>CLIFTON S. EUSEBIO</u>	

B. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause (a) <u>PULMONARY TUBERCULOSIS</u> Antecedent cause(s) (b) <u>Cardiovascular Heart disease</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Acute Congestive Heart Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> <u>unknown</u> <u>Sudden</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
19a. DATE OF OPERATION <u>NONE</u> 19b. MAJOR FINDINGS OF OPERATION <u>NONE</u>		21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY INJURY OCCURRED HOW DID INJURY OCCUR? While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/>, accident <input type="checkbox"/>, suicide <input type="checkbox"/>, homicide <input type="checkbox"/>, undetermined <input type="checkbox"/>.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> DATE THEREOF <u>4-4-51</u> NAME OF CEMETERY OR CREMATORY <u>Bethesda Hill</u> LOCATION (City, town, or county) <u>D.C. 19</u> (State) <u>4.2.51</u>		24. FUNERAL DIRECTOR <u>Wally's Funeral Home 522-8th St. S.E.</u> ADDRESS <u>585246 Wash. D.C.</u>	
DATE REC'D BY LOCAL REG. <u>April 2-1951</u> REGISTRAR'S SIGNATURE <u>Edna F. Sollins</u>		DATE SIGNED <u>4.2.51</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>P. G.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cheverly</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Riverdale</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince George General Hospital</u>		STREET ADDRESS (If rural, give location) <u>6015 Sacas Avenue</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Rose</u> (Middle) <u>Dredge</u> (Last) <u>Dredge</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>21</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 30 1895</u>
9. AGE last birthday <u>55</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>John N. Betting</u>		14. MOTHER'S MAIDEN NAME <u>Maggie Lutz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMATION AND ADDRESS <u>Eleanor Lutz Riverdale Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Carcinoma of pancreas & metastases

INTERVAL BETWEEN ONSET AND DEATH

2 mo. (P)

Antecedent cause(s)

(b)

Cachexia

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 4-15, 1951, to 4-21, 1951, that I last saw the deceased alive on 4-20, 1951, and that death occurred at 9:45 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>4/24/51</u>	<u>Cedar Hill</u>	<u>Summerville Md</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>4/22/51</u>	<u>Amanda Dorney</u>	<u>E. Kasche sons Hyattsville Md.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 24 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

3996

Reg. Dist. No. 230

1. PLACE OF DEATH COUNTY <u>Prince George</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Immundale</u> TOWN <u>Immundale</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Normal Institute</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Prince George</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Immundale</u> TOWN <u>Immundale</u> STREET ADDRESS (If rural, give location) <u>Normal Institute</u>	
3. NAME OF DECEASED (Type or Print) <u>Joseph</u>	(First) <u>Joseph</u>	(Middle) <u>Dymkowski</u>	(Last) <u>Dymkowski</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	4. DATE OF DEATH <u>4-3-1951</u>
8. DATE OF BIRTH <u>July 4, 1882</u>	9. AGE last birthday <u>68</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Apprentice Normal Inst.</u>
11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>Vincent Dymkowski</u>	14. MOTHER'S MAIDEN NAME <u>Anna (Unknown)</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY No. <u>(If yes, give war or dates of service)</u>	17. INFORMANT <u>Brother Fidelis - Brother</u>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Acute congestive heart failure</u>	
Antecedent cause(s) (b) <u>Cardiovascular renal disease</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Nnt while at work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION OR OTHER DISPOSITION (Specify) <u>Buried</u>	DATE THEREOF <u>April 9, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Apprentice Normal Inst.</u>	LOCATION (City, town, or county) <u>BELTSVILLE, P.O. R.G.O.</u>
DATE REC'D BY LOCAL REG. <u>April 3rd 1951</u>	REGISTRAR'S SIGNATURE <u>John D. Smith</u>	24. FUNERAL DIRECTOR <u>W.W. Chambers Co - Rockville Md</u>	ADDRESS <u>590888</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 7 1951
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. **3997**
242

1. PLACE OF DEATH - COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE Maryland COUNTY P. Ger	
CITY (If outside corporate limits, write RURAL and give nearest town) Dist Heights		CITY (If outside corporate limits, write RURAL and give nearest town) Dist Heights	
TOWN Dist Heights		TOWN Dist Heights	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) 7609-FOSTER STREET	
3. NAME OF DECEASED (First) JOHN (Middle) JOSEPH (Last) FARRELL		4. DATE OF DEATH (Month) April (Day) 5 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Dec 2, 1868
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Commercial	11. BIRTHPLACE (State or foreign country) Boston Mass
13. FATHER'S NAME Thomas Farrell		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY NO. 016-163478	17. INFORMANT AND ADDRESS Helmina b Farrell

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Carcinomatosis			2 years
154X Antecedent cause(s) (b) Adenocarcinoma - Rectum			3 years
46d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Hypertensive Arterio-sclerosis			10 years
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **Sept.**, 19**50**, to **April 5**, 19**51**, that I last saw the deceased alive on **2 April**, 19**51**, and that death occurred at **11:40 P.** m., from the causes and on the date stated above.

SIGNATURE Sidney W. Lowry		ADDRESS 400 - 3829 - Pennsylvania Ave SE. Wash. 20, D.C.		DATE SIGNED 4/5/51
23. BURIAL, CREMATION REMOVAL (Specify)	DATE 4/9/51	NAME OF CEMETERY OR CREMATORY St Mary	LOCATION (City, town, or county) Salem Mass	(State)
DATE REC'D BY LOCAL REG. Apr 6	REGISTRAR'S SIGNATURE E. F. Collins	24. FUNERAL DIRECTOR Chas Chamber's	ADDRESS 517-11 St SE	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

512806 Wash DC

RECEIVED
APR 12 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 3998 245

1. PLACE OF DEATH COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>PRINCE GEO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7301 HILTON AVE.</u>		STREET ADDRESS (If rural, give location) <u>7301 HILTON AVE.</u>	
3. NAME OF DECEASED (Type or Print) <u>FRIEDA REGINA Fleisher</u>		4. DATE OF DEATH <u>Apr. 11</u> 19 <u>57</u>	
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>SEPT. 14 1870</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	9. AGE last birthday <u>80</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
13. FATHER'S NAME <u>ANDREW ARKEDER</u>		12. CITIZEN OF WHAT COUNTRY? <u>GERMANY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		11. BIRTHPLACE (State or foreign country) <u>TAKOMA PARK, MD.</u>	
16. SOCIAL SECURITY No. <u> </u>		14. MOTHER'S MAIDEN NAME <u>SUSAN REGINA KONRAD</u>	
17. INFORMANT AND ADDRESS <u>MRS FRIEDA C. HUXTABLE, 7301 HILTON AVE., TAKOMA PARK, MD.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Pneumonia

INTERVAL BETWEEN ONSET AND DEATH

20 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 22, 1957, to Apr 11, 1957, that I last saw the deceased

alive on Apr 11, 1957, and that death occurred at 9:00 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BURIAL APR. 13, 1957 FT. LINCOLN CEMETERY BLADENSBURG RD AT EASTERN AVE, MD
April 11, 1957 John H. Andrews J. ARTHUR WALTERS, 254 CARROLL ST., TAKOMA PARK, D.C.

RECEIVED
BUREAU V. L. 18

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 3999 245

1. PLACE OF DEATH COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Annapolis		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Seland Memorial Hosp		STREET ADDRESS (If rural give location) 911-8. Linwood St	
3. NAME OF DECEASED (Type or Print)	(First) Francis (Middle) Joseph (Last) Ford	4. DATE OF DEATH	(Month) 4 (Day) 2 (Year) 1951
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 4-8-32
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marine		10b. KIND OF BUSINESS OR INDUSTRY U.S.A.	9. AGE last birthday 18 1/2 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Ernest Francis Ford		14. MOTHER'S MAIDEN NAME Lillian Josephine Kaiser	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
		17. INFORMANT St. J. G. Roy E. Winnie	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a)

Antecedent cause(s) (b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

Hemorrhage & shock.
Compound - comminuted fracture of skull bone
Cerebral concussion

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

Automobile collision

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.	PLACE OF INJURY (Home, farm, factory, street, office, etc.) Street	(CITY OR TOWN) (COUNTY) (STATE) Munsterick - Pr. Geo. Md.
TIME (Month) (Day) (Year) (Hour) OF INJURY 4-2-51 4:40 A.M.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? Collision car driven by deceased tractor

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Removal	4-3-51	Baltimore Natl. Cem.	Baltimore, Md	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
4-2-51	Amanda Downey	Wooten Funeral Home	575 916	
April 4-51	Janus Sever	301-E. Capital St. Wash. D.C.		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 5 1951
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 241

04000

1. PLACE OF DEATH- COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE District of Columbia COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Andrews Air Force Base		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) 2122 13th St., S.E.	
3. NAME OF DECEASED (Type or Print)	(First) Barney	(Middle)	(Last) Forquer
4. DATE OF DEATH	(Month) April	(Day) 24	(Year) 1951
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 1895
9. AGE last birthday 55 yrs.		10. BIRTHPLACE (State or foreign country) Pennsylvania	11. CITIZEN OF WHAT COUNTRY? USA
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor Foreman		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World War I	
16. SOCIAL SECURITY No. 211-01-1521		17. INFORMANT AND ADDRESS Son	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
(a) Immediate cause Coronary heart disease			
(b) Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last			
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None			
19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION None		
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) Andrews Air Force Base, Prince Georges	(COUNTY) (STATE) MD
TIME (Month) (Day) (Year) (Hour) OF INJURY m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at 1:00 P.m. , from the causes and on the date stated above.			
SIGNATURE J. C. Gardner		ADDRESS 1050th Medical Group	
DATE SIGNED 24 April 1951			
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF 27-APRIL-1951	NAME OF CEMETERY OR CREMATORY ARLINGTON NATL	LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA
DATE REC'D BY LOCAL REG. 24 April 1951	REGISTRAR'S SIGNATURE Alma R. Hall	24. FUNERAL DIRECTOR W. W. CHAMBERS Co WASH D.C.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

VS. A13

523916

RECEIVED
APR 2 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

04001

1. PLACE OF DEATH COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Prince George's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Capitol Heights</u>	
TOWN <u>Cheverly</u>		TOWN <u>Capitol Heights</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince George General Hosp</u>		STREET ADDRESS (If rural, give location) <u>5807 Central Ave.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Thomas John Fowler Sr.</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 10 1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>19 Dec 1893</u>
9. AGE last birthday <u>57</u> yrs.		10. AGE last birthday (If under 1 year) (If under 24 hrs) Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Huckster</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Samuel Fowler</u>		14. MOTHER'S MAIDEN NAME? <u>Mary C.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Hosp Record</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Congestive Heart Failure

INTERVAL BETWEEN ONSET AND DEATH

6 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Pneumonia Base Right Lung

24 hrs

(c) Arteriosclerotic Heart Disease

2 Years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While at Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 4, 1951, to April 10, 1951, that I last saw the deceased alive on April 9, 1951, and that death occurred at 5:50 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

W. Suit Ritchie MD 7005 Ritchie Road S.E. Wash 19 DC
4/13/1951 Epiphany Church Cem Forestville md.
Apr. 10 1951 Amanda Downing St. St. Chambers Cms 517-11-188
1951 430 636

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 11 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 239

04002

1. PLACE OF DEATH- COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>New Jersey</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mendham</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Laurel Sanitarium</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>KATE</u> (First) <u>WATKINS</u> (Middle) <u>GERHARDT</u> (Last)		4. DATE OF DEATH <u>April</u> (Month) <u>4</u> (Day) <u>1951</u> (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>6-16-1865</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>85</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Claybourne Watkins</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Abbott</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Virginia Stulerman, Mendham, N.J.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Influenza</u>			<u>10 Days</u>
Antecedent cause(s) (b) <u>Chronic Myocarditis</u>			<u>Many years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Chronic Endocarditis</u>			<u>" "</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>General Arteriosclerosis</u>			<u>" "</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 5-15-, 1949, to 4-4-, 1951, that I last saw the deceased alive on 4-3-, 1951, and that death occurred at 8:50 A. m., from the causes and on the date stated above.

SIGNATURE James P. Sands, M.D. (Degree or title) ADDRESS Laurel Sanitarium, Laurel, Md. DATE SIGNED 4-4-1951

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>April 11, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Washington Natl Cemetery</u>	LOCATION (City, town, or county) <u>Washington, Virginia</u>	(State)
DATE REC'D BY LOCAL REG. <u>April 10-1951</u>	REGISTRAR'S SIGNATURE <u>M. Beasly</u>	24. FUNERAL DIRECTOR <u>De Witt Davidson, Laurel, Md</u> ADDRESS		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 16 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

04003

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 231

1. PLACE OF DEATH COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>New Jersey</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Morningside</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cranford</u>	
TOWN <u>302 Poplar Road</u>		TOWN <u>319 Hampton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Erwin</u> (First) <u>m</u> (Middle) <u>Gruyer</u> (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 8</u> 19 <u>57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 25, 1913</u>
9. AGE last birthday <u>43</u> yrs.	10. KIND OF BUSINESS OR INDUSTRY <u>Asphalt business</u>	11. BIRTHPLACE (State or foreign country) <u>Woodbury, Pa</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>Nelson Gruyer</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Wainland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Leon W. Gruyer - Martinsburg, Pa</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) Asphyxia
(b) Suffocation
(c) Conflagration

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY <u>House</u>	(CITY OR TOWN) <u>Morningside, Pa.</u>	(COUNTY) <u>Pa.</u>	(STATE) <u>Pa.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>4-5-51-4:05 P.m.</u>	INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>A. 50 ft. plane B. 25' crashed into house where deceased was waiting</u>			

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	DATE THEREOF <u>13/11/01</u>	NAME OF CEMETERY OR CREMATORY <u>Cranford</u>	LOCATION (City, town, or county) <u>Pa.</u>	(State) <u>Pa.</u>
DATE REC'D BY LOCAL REG. <u>April 10</u>	REGISTRAR'S SIGNATURE <u>Amanda Downey</u>	24. FUNERAL DIRECTOR <u>Eusebio Sosa</u>	ADDRESS <u>Hyattsville, Md</u>	

1951

290 376

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 26 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 245

04004

1. PLACE OF DEATH COUNTY <u>Prince Geo.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>D.C.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>WATTSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>WASHINGTON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4226 Nicholson St</u>		STREET ADDRESS (If rural, give location) <u>517 Quincy St. N.W.</u>	
3. NAME OF DECEASED (Type or Print) <u>ELLA</u> (First) <u>L.</u> (Middle) <u>Herold</u> (Last)		4. DATE OF DEATH Month <u>4</u> - Day <u>21</u> - Year <u>51</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>11/23/1888</u> yrs. <u>62</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10h. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday If under 1 year Months <u>4</u> Days <u>28</u> If under 24 hrs. Hours <u>—</u> Min. <u>—</u>
11a. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Nathan Ballard</u>		14. MOTHER'S MAIDEN NAME <u>Emily Giffard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>MArie Franklin</u>	
17. INFORMANT AND ADDRESS <u>4226 Nicholson St. Watts, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>422.1</u> <u>Chronic Myocarditis</u>	(a)	<u>2 yrs +</u>
Antecedent cause(s) <u>93d.</u> <u>Generalized Arteriosclerosis</u>	(b)	<u>2 yrs +</u>
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19h. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 25, 1949, to April 21, 1951, that I last saw the deceased alive on April 19, 1951, and that death occurred at 3:27 A.M., from the causes and on the date stated above.

SIGNATURE Harry Zinck, M.D. (Degree or title) ADDRESS 900-17th St N.W. Wash. D.C. DATE SIGNED 4/21/51

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THERE OF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>April 23 1951</u>	<u>St. Sincola Cemetery</u>	<u>Colman (Manor) Park, Wash. D.C.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>April 21 1951</u>	<u>Mrs. Jas. Severel Deputy</u>	<u>W. S. L. Lines Co.</u>	<u>2901-14th St. N.W. Wash. D.C.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

APR 24 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04005

Reg. Dist. No. 23.1

1. PLACE OF DEATH - COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>	
TOWN <u>Cheverly</u>		TOWN <u>College Park</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince Geo Gen Hosp</u>		STREET ADDRESS (If rural, give location) <u>7015 Foodham Ct</u>	
3. NAME OF DECEASED (First) <u>Mildred</u> (Middle) <u>Heimer</u> (Last) <u>Heimer</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>13</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>4-3-91</u>
9. AGE last birthday <u>60</u> yrs.		10. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Canada</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Wm Caddoo</u>	
14. MOTHER'S MAIDEN NAME <u>Elizabeth Ann Matthews</u>		15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give year or dates of service)	
16. SOCIAL SECURITY No. <u>—</u>		17. INFORMANT AND ADDRESS <u>Dr Paul A. Heimer College Park Md</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Massive anterior coronary thrombosis

INTERVAL BETWEEN ONSET AND DEATH 36 hr.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Obesity: Previous resection of antebial thyroid gland - 5 mo. before

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 4-11, 1951, to 4-13, 1951, that I last saw the deceased

alive on 4-13, 1951, and that death occurred at 6:20 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>4/16/51</u>	<u>Arlington Cemetery</u>	<u>Arlington</u>	<u>Pa</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>April 15</u>	<u>Amanda Downey</u>	<u>E. Gude and Spatterville Rd</u>		

1951

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 17 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

04006

1. PLACE OF DEATH COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Prince George's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>	
TOWN <u>Prince George General Hosp</u>		TOWN <u>Brandywine</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Annie</u> <u>R.</u> <u>Hoff</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April</u> <u>8</u> <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>3-22-1878</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	9. AGE last birthday <u>73</u> yrs.
13. FATHER'S NAME <u>Wilhelm Blochert</u>		12. CITIZEN OF WHAT COUNTRY <u>Penn.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>Caroline</u> ?	
16. SOCIAL SECURITY No. <u>Unknown</u>		17. INFORMANT AND ADDRESS <u>Hosp. Records</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Mono cytic Leukemia

INTERVAL BETWEEN ONSET AND DEATH

7 yrs

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.Persistent atony of Colon & impactions

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

3-10-51Colectomy

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m. Work ☐ Not While at Work ☐ Not While at Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-23, 1951, to 4-8, 1951, that I last saw the deceasedalive on 4-8, 1951, and that death occurred at 4:30 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

April 9, 1951Amanda CoroneySimmonsBro. 2007-Nichols Ave. S.E.Wash. D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write nearest town) TOWN <u>Laurel</u>		CITY (If outside corporate limits, write nearest town) TOWN <u>Kensington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Laurel Sanitarium</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>JOSEPH W. HOPKINS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 7 - 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>2-1-1857</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Store</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE last birthday <u>94</u> yrs.
13. FATHER'S NAME <u>Joseph Hopkins</u>		14. MOTHER'S MAIDEN NAME <u>Martha Harper</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Mr. R. T. Green, Kensington, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Chronic Myocarditis</u>				<u>Many Years</u>
Antecedent cause(s) (b) <u>Chronic Endocarditis</u>				" "
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>General Arteriosclerosis</u>				" "
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-15, 1949, to 4-7, 1951, that I last saw the deceased alive on 4-6, 1951, and that death occurred at 7:15 A.M., from the causes and on the date stated above.

SIGNATURE James P. Sands, M.D. (Degree or title) ADDRESS Laurel Sanitarium, Laurel, Md. DATE SIGNED 4-7-1951

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>4-11-51</u>	<u>St. Johns Cemetery</u>	<u>Forest Glen, Md.</u>
DATE RECD BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>April 7-51</u>	<u>M. Pashears</u>	<u>Robert A. Humphrey</u>	<u>Bethesda</u>

CDC 290648nd.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 10 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04908

CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH- COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits, write RURAL and nearest town) <u>Rural, Berwyn</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Berwyn</u>	
TOWN <u>Berwyn</u> LENGTH OF STAY (in this place) <u>47 years</u>		TOWN <u>Rural, Berwyn</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>		STREET ADDRESS (If rural, give location) <u>None</u>	
3. NAME OF DECEASED (First) <u>AMONNIA</u> (Middle) <u>LEE</u> (Last) <u>JEFFERIES</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>14</u> (Year) <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 28, 1886</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	9. AGE last birthday <u>64</u> yrs.	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
12. FATHER'S NAME <u>John M. Acora</u>	13. MOTHER'S MAIDEN NAME <u>Margaret Ellen Brooks</u>	14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	15. SOCIAL SECURITY No. <u>None</u>
16. INFORMANT AND ADDRESS <u>Howard D. Jefferies, 2nd. College PK.</u>	17. CITIZEN OF WHAT COUNTRY? <u>USA</u>		

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Bronchopneumonia</u>				<u>3 days</u>	
Antecedent cause(s) (b) <u>Myocardial Insufficiency</u>				<u>20 yrs.</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Generalized Arteriosclerosis</u>				<u>20 yrs.</u>	
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death. <u>Dementia senilis</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Apr 13, 1957, to Apr 14, 1957, that I last saw the deceased alive on Apr 13, 1957, and that death occurred at 4:30 a.m., from the causes and on the date stated above.

SIGNATURE <u>J. M. Warren M.D.</u>		ADDRESS <u>Lancaster</u>		DATE SIGNED <u>4/14/57</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)	
<u>Burial</u>	<u>4/16/57</u>	<u>St. John's Cemetery</u>	<u>Beltsville, Md.</u>		
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR			
<u>April 14-1957</u>	<u>John D. Smutte</u>	<u>W.W. Chambers Co., Beltsville Md.</u>			
		<u>Aurendale Md.</u>			

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3

RECEIVED

APR 17 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 105

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Accocheek</u> TOWN <u>Accocheek</u> LENGTH OF STAY (in this place) <u>4 yr</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Accocheek</u> TOWN <u>Accocheek</u> STREET ADDRESS (If rural, give location) <u>Rural #1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Accocheek, Md</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>JAMES HARRY JOHNSON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 9 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>March 23/1883</u>
9. AGE last birthday <u>68</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Prince Georges Co Md</u>	11. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired attendant hospital and Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
13. FATHER'S NAME <u>Clinton Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Sarah E Coombs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Daniel T Johnson Arlington, Va</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Acute Coronary Occlusion

INTERVAL BETWEEN ONSET AND DEATH

Sudden

Antecedent cause(s)

(b) General Arteriosclerosisunknown(c) 1420.1 940

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. 1420.1 940

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

Nov 1950 unknown

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>none</u>	(CITY OR TOWN) <u>Accocheek P.G. Co. Md</u>	(COUNTY) <u>Prince Georges</u>	(STATE) <u>Md</u>
TIME (Month) (Day) (Year) (Hour) <u>none</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>ing injury</u>		

22. I hereby certify that I attended the deceased from death to death, 19....., that I last saw the deceasedSIGNATURE Paul C Van Hatten M.D. Asst. Coroner Washington ADDRESS 1900 19th St NW Washington D.C. DATE SIGNED April 9 1951

23. BURIAL OR CREMATION (Specify) <u>Removal</u>	DATE THEREOF <u>April 12-51</u>	NAME OF CEMETERY OR CREMATORY <u>St Joseph</u>	LOCATION (City, town, or county) <u>Pomfret</u>	(State) <u>Md</u>
DATE REC'D BY LOCAL REG. <u>4/10/51</u>	REGISTRAR'S SIGNATURE <u>M.L. Houser</u>	24. FUNERAL DIRECTOR <u>Smith & Hagan</u>	ADDRESS <u>Wallops Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

730804

BUREAU V. S.

APR 12 1951

RECEIVED

COPY SENT TO LOCAL REGISTRAR No. DATE Apr. 13, 51

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

04010

Reg. Dist. No. 242

1. PLACE OF DEATH- COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>P. George</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington 1905</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington 1905</u>	
TOWN <u>Washington 1905</u>		TOWN <u>Washington 1905</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6236 Marlboro Road SE</u>		STREET ADDRESS (If rural, give location) <u>6236 Marlboro Road SE</u>	
3. NAME OF DECEASED (Type or Print) <u>Ala Lenton Karickhoff</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 15 1957</u>	
5. SEX <u>me</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Aug 14 1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>	9. AGE last birth day <u>74</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTH PLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>David C Karickhoff</u>		14. MOTHER'S MAIDEN NAME <u>—? Strader</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT <u>wife Bessie M Karickhoff</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) <u>Acute Congestive Heart failure</u>		<u>Immediate</u>
(b) <u>Carcinoma of Liver</u>		<u>6 mo</u>
(c) <u>General Arteriosclerosis</u>		<u>unknown</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION <u>none</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> <u>None</u>		(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>none</u>	PLACE (Home, farm, factory, street, or office bldg., etc.) OF INJURY <u>none</u>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION OR REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>4/18/57</u>	NAME OF CEMETERY OR CREMATORY <u>Adel Defs Cemetery Washington 1905</u>	LOCATION (City, town, or county) (State) <u>Buckhamon W Va</u>
DATE REC'D BY LOCAL REG <u>April 15 1957</u>	REGISTRAR'S SIGNATURE <u>Edna F. Collins</u>	24. FUNERAL DIRECTOR <u>W. W. Chambers</u>	ADDRESS <u>Co. 517 11th St</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 23 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 342

04011

1. PLACE OF DEATH- COUNTRY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>P. Ger.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant Md</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>413-70th Place Seat Pleasant Md.</u>		STREET ADDRESS (If rural, give location) <u>413-70th Place</u>	
3. NAME OF DECEASED (First) <u>Maurice</u> (Middle) <u>Thomas</u> (Last) <u>Kelly Sr.</u>		4. DATE OF DEATH (Month) <u>Apr</u> (Day) <u>15</u> (Year) <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug 11 1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>barber retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>	9. AGE last birthday <u>66</u> yrs. If under 1 year Months Days If under 24 hrs Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George Kelly - Baltimore Md</u>		14. MOTHER'S MAIDEN NAME <u>Barbara - (unlabeled)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give where or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-05-3679</u>	
17. INFORMANT AND ADDRESS <u>Maurice Thomas Kelly Jr. 413-70th Place Seat Pleasant Md.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Acute Congestive Heart failure</u>	<u>30 min.</u>
422.1 Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Chr. Myocarditis</u>	<u>6 weeks</u>
93d	(c) <u>General Arteriosclerosis</u>	<u>unknown</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>		

19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION <u>none</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> <u>Major Trauma</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>Seat Pleasant</u>	(CITY OR TOWN) (COUNTY) (STATE) <u>P. George Md</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>no injury</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>no injury</u>

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4/18/51</u>	NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>	LOCATION (City, town, or county) (State) <u>Colmar Manor Md</u>
DATE REC'D BY LOCAL REG. <u>4/16/51</u>	REGISTRAR'S SIGNATURE <u>Carrie F. Campbell</u>	24. FUNERAL DIRECTOR <u>Brooks some Hyattsville Md</u>	ADDRESS <u>740849</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 234

04012

1. PLACE OF DEATH- COUNTY <u>PR. Georges Co.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>PR. Georges</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>7805 Ft. Foote Rd.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>FORT Foote Maryland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>7805-FORT Foote Road</u>	
3. NAME OF DECEASED (Type or Print) <u>George F. Kerby</u>		4. DATE OF DEATH <u>April 12</u> 19 <u>51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>Sept. 24-1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>	9. AGE last birthday <u>59</u> yrs. If under 1 year 1 year 24 hrs. Months. Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Camp Springs, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Kerby</u>		14. MOTHER'S MAIDEN NAME <u>MARY Marden</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Howard M. Kerby - 7009-MARLBORO PIKE, MD</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause <u>420.1 Coronary Thrombosis</u>		(a) <u>Coronary Thrombosis</u>			
Antecedent cause(s) <u>94a Hypertension</u>		(b) <u>Hypertension</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan 41, 1951, to Apr 12, 1951, that I last saw the deceased alive on Apr 11, 1951, and that death occurred at 6:05 A.m., from the causes and on the date stated above.

SIGNATURE <u>Schwartzman, M.D.</u>		(Degree or title)		ADDRESS <u>2015 Nichols St</u>		DATE SIGNED <u>4/12/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE <u>Burial April 14-51</u>		NAME OF CEMETERY OR CREMATORY <u>ST. BARNABAS Cem</u>		LOCATION (City, town, or county) (State) <u>OXON HILL, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>April 12-51</u>		REGISTRAR'S SIGNATURE <u>Theresa & Beall</u>		24. FUNERAL DIRECTOR <u>Simmons Bros</u>		ADDRESS <u>2007-Nichols Ave Wash 2000C 1009688</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Coroner notified & approved.
Schuytman, M.D.



MARYLAND STATE DEPARTMENT OF HEALTH

04013

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 245

1. PLACE OF DEATH COUNTY Prince Georges MARYLAND CITY (If outside corporate limits, write RURAL, and give nearest town) Hyattsville OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS Rt. 1 - Box 100 Powder Mill Road		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland - Prince Georges COUNTY CITY (If outside corporate limits, write RURAL, and give nearest town) Hyattsville OR TOWN STREET ADDRESS 1417 B Powder Mill Road	
3. NAME OF DECEASED (Type or Print) Joseph (First) Ivi (Middle) Mal (Last)		4. DATE OF DEATH (Month) April (Day) 12 (Year) 1957	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Oct 15, 1870
9. AGE last birthday 80 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Statistician, U.S.G.	
11. BIRTHPLACE (State or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Georgiana Mal.			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Acute congestive heart failure		
Antecedent cause(s) (b) Arteriosclerotic heart disease 420.0 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d (c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ therean and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. REMOVAL, CREMATION, DATE THEREOF 4/13/51 NAME OF CEMETERY OR CREMATORY Lee's Crematorium Wash. D.C.	LOCATION (City, town, or county) Hyattsville, Md.	(State) Md.
DATE REC'D BY LOCAL REG. April 13, 1951 REGISTRAR'S SIGNATURE James Severy	24. FUNERAL DIRECTOR J.W. Lee's Sons Co - 300 4th NE.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 16 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 239

04014

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Laurel Sanitarium</u>		STREET ADDRESS <u>2802 St. Paul St.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>CLARA O. de H. LAITHE</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 1 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>about 1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Rudolph Cehl de Hattersheim</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Hellweg</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>-</u>	
		17. INFORMANT AND ADDRESS <u>Henry M. Laith 2802 St. Paul St. Balto. Md.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>422.1</u> Antecedent cause(s) <u>92d</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(a) <u>Chronic Myocarditis</u> (b) <u>Chronic Endocarditis</u> (c) <u>Broncho pneumonia</u> <u>General Arteriosclerosis</u>	<u>Several years</u> <u>Several years</u> <u>1 week</u> <u>Many years</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 5-15-, 1949, to 4-1-, 1951, that I last saw the deceased alive on 4-1-, 1951, and that death occurred at 7:30 P.m., from the causes and on the date stated above.

SIGNATURE James P. Sands, M.D. (Degree or title) ADDRESS Laurel Sanitarium, Laurel, Md. DATE SIGNED 4-1-1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>4/4/51</u>	NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
DATE REC'D BY LOCAL REG. <u>4/4/51</u>	REGISTRAR'S SIGNATURE <u>A. W. Woodcock</u>	24. FUNERAL DIRECTOR <u>W. W. Meeker and Son 805 N. Calvert St.</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 245

04015

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Colmar Manor</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Colmar Manor</u>	
TOWN <u>Colmar Manor</u>		TOWN <u>Colmar Manor</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3701 Eastern Ave</u>		STREET ADDRESS (If rural, give location) <u>3416 - 40 Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>GRACE LORRAINE LEIZEAR</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>APRIL 12 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>11/16/1919</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE last birthday <u>31</u> yrs. If under 1 year: Months Days If under 24 hrs: Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lloyd Jenkins</u>		14. MOTHER'S MAIDEN NAME <u>McIntyre</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT NAME <u>Charles C Leizear</u>		18. ADDRESS <u>Colmar Manor Md</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Generalized Carcinomatosis to abdomen & sacral nerve plexusINTERVAL BETWEEN ONSET AND DEATH
6-8 Mos

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Carcinoma of cervix1 1/2 yr11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from JAN 1950, to APRIL 1951, that I last saw the deceased alive on 4-8, 1951, and that death occurred at 9:30 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4/14/51</u>	NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	LOCATION (City, town, or county) <u>Smithland Md</u>	(State)
DATE REC'D BY LOCAL REG <u>April 14, 1951</u>	REGISTRAR'S SIGNATURE <u>James Leroy</u>	24. FUNERAL DIRECTOR <u>F. Kasche sons</u>	ADDRESS <u>Nyattsville Md</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 16 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chillum</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chillum</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>713 Chillum Road</u>	
3. NAME OF DECEASED (First) (Middle) (Last) (Type or Print) <u>JOHN TODD LENIHAN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 7, 1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>6/12/49</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>1</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBERT E. LENIHAN</u>		14. MOTHER'S MAIDEN NAME <u>Aveliffe A. Schaible</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>ROBERT E LENIHAN -</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

HYDROCEPHALUS, COMMUNICATING

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.UREMIA, ACIDOSIS.

INTERVAL BETWEEN ONSET AND DEATH

SINCE BIRTH

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from JULY....., 1949, to Apr 7....., 1951....., that I last saw the deceased alive on 2 April....., 1951....., and that death occurred at 6:40 p.m......, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

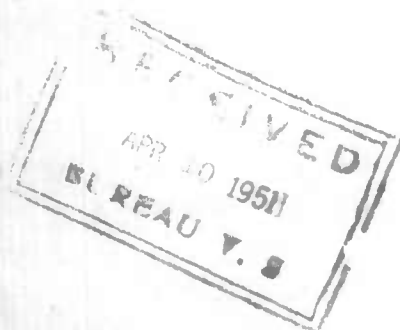
ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>4/11/51</u>	<u>ARLINGTON NAT'L</u>	<u>FT MYER, VA.</u>	
DATE REC'D BY LOCAL REG	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>April 9 1951</u>	<u>Mrs. Jan. Severo</u>	<u>Joseph Gawler's Sons</u>	<u>Wash. D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

04017

Reg. Dist. No. 242

1. PLACE OF DEATH - COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Pr. George's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Farmount Heights</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Farmount Heights</u>	
TOWN <u>Farmount Heights</u>		TOWN <u>Farmount Heights</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Ave & Jay St.</u>		STREET ADDRESS <u>Eastern Ave & Jay St.</u>	
3. NAME OF DECEASED (First) <u>William</u> (Middle) <u>F.</u> (Last) <u>Luck</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>22</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov-22-1894</u>
9. AGE last birthday <u>56</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>	
11. BIRTHPLACE (State or foreign country) <u>Danville, Va</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>Wagwood Luck</u>		14. MOTHER'S MAIDEN NAME <u>Martha Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>W.W.I.</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>James R. Coleman - Cousin</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Asphyxia

Antecedent cause(s) (b) Suffocation

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Conflagration in home

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	(CITY OR TOWN) <u>Farmount Hts - Pr. Geo - Md.</u>	(COUNTY) <u>Pr. Geo - Md.</u>	(STATE) <u>Md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>4-22-51 3:10 A.M.</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Conflagration in home of deceased.</u>		

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>	DATE THEREOF <u>April 28 1951</u>	NAME OF CEMETERY OR CREMATORY <u>W. Ernest Jones Co.</u>	LOCATION (City, town, or county) <u>Washington, D.C.</u>	(State) <u>D.C.</u>
DATE REC'D BY LOCAL REG. <u>4/24/51</u>	REGISTRAR'S SIGNATURE <u>Carrie F. Campbell</u>	24. FUNERAL DIRECTOR <u>W. Ernest Jones Co.</u>	ADDRESS <u>1438 N. St. N.W.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A T

RECEIVED

APR 30 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

04018

2070

1. PLACE OF DEATH- COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland- Prince George's</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cottage City</u>	
TOWN <u>Prince Geo. Gen. Hospital</u>		TOWN <u>4 days</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>4102 Parkwood Street</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Evelyn A Lyons</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Apr 10 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>11 June 1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>62</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Mins.
11. BIRTHPLACE (State or foreign country) <u>Washington - D.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William H. Dice</u>		14. MOTHER'S MARRIED NAME <u>Jessie Yager</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Walter A. Lyons Husband As above</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral Hemorrhage

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Diabetes mellitus

(c) Hypertensive Cardio-renal disease

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-7, 1951, to 4/2, 1951, that I last saw the deceased

alive on 4/2/51, 1951, and that death occurred at 4:50 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

George H. Haggard M.D. 3717-38th Ave. Cottage City, Md. 4/2/51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

4/3/51 Amanda Souney

F. Gasch's Sons Hyattsville, Md.

E. Gasch's Sons

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 5 1951
BUREAU Y. S.

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 243

1. PLACE OF DEATH CITY <u>Bowie</u> STATE <u>MARYLAND</u> OR TOWN <u>Bowie</u> LENGTH OF STAY (in this place) <u>Working</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY _____ CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lanell</u> OR TOWN <u>Lanell</u> STREET ADDRESS (If rural, give location) <u>28 Woodale Street</u>	
3. NAME OF DECEASED (Type or Print) <u>Elbert</u> (First) <u>Allen</u> (Middle) <u>Mahan</u> (Last)		4. DATE OF DEATH <u>4-12-1951</u> (Month) (Day) (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>2-19-1907</u>
9. AGE last birthday <u>44</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	11. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General painting</u>	
13. FATHER'S NAME <u>Elizah Mahan</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Livingston</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes U.S.A.</u>		16. SOCIAL SECURITY No. <u>480-03-0055</u>	
17. INFORMANT AND ADDRESS <u>Blanche Mahan-Same-480</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Hemorrhage & shock</u> Antecedent cause(s) (b) <u>Laceration of spleen, lacerated kidney</u> Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Crushed chest-fractured pelvis</u>		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
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21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg, etc.) OF INJURY <u>Water tank</u>	(CITY OR TOWN) <u>Bowie - Prince Georges, Md.</u> (COUNTY) _____ (STATE) _____
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>4-12-51 12:15 p.m.</u>	INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>Fell from scaffolding on which he was working, 70 ft.</u>

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION OR REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>April 15 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Lanell Hill</u>	LOCATION (City, town, or county) <u>Lanell</u> (State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>4-18-1951</u>	REGISTRAR'S SIGNATURE <u>Agnes M. Jungling</u>	24. FUNERAL DIRECTOR <u>Ridgely Selby</u>	ADDRESS <u>401 Woodale Street Lanell, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 19 1951
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 04020 232

1. PLACE OF DEATH - COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington 20 DC</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington 20 DC (Rural)</u>	
TOWN <u>3 1/2</u>		TOWN <u>3 1/2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6704 Tucker Road S.E. Oxon Hill, Md.</u>		STREET ADDRESS (If rural, give location) <u>6704 Tucker Road S.E. (Oxon Hill, Md.)</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Benjamin Therman Mahoney</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 25 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 17 1907</u>
9. AGE last birthday <u>50 yrs.</u>		10. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY No. <u>6704 Tucker Rd SE</u>	
17. INFORMANT AND ADDRESS <u>Helene E.S. Jones Mahoney (wife)</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Acute Coronary Occlusion</u> 1 hour			
Antecedent cause(s) (b) <u>General Arteriosclerosis</u> unknown			
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Over average weight</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>none</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> <u>Accident</u>		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>none</u>		INJURY OCCURRED While at <u>work</u> Not while at work <input checked="" type="checkbox"/>	
HOW DID INJURY OCCUR? <u>none</u>			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>Paul C. Chur Yatta M.D., Act. Dep. Comm.</u>		ADDRESS <u>Washington 1950</u>	
DATE SIGNED <u>Apr 26/1957</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>4/30/57</u>	
NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial</u>		LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
24. FUNERAL DIRECTOR <u>Ritchie Bros.</u>		ADDRESS <u>Upper Marlboro, Md.</u>	

730869

RECEIVED
APR 30 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Penns.</u> COUNTY <u>Allegheny</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Fauvel</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pittsburg</u>	
TOWN <u>Fauvel</u>		TOWN <u>Pittsburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Fauvel Sanitarium</u>		STREET ADDRESS <u>900 College Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>MARGARET ALICE MCCAUSLAND</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>2</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>None</u>	8. DATE OF BIRTH <u>6-11-1862</u>
9. AGE last birthday <u>88</u> yrs.		10. If under 1 year If under 2 hrs. Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert L. Crouch</u>		14. MOTHER'S MAIDEN NAME <u>Anna F. Brockstee</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Henry Haas, 900 College Ave Pittsburg, Pa.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH <u>Many Years</u>
Immediate cause (a) <u>Chronic Myocarditis</u>			
Antecedent cause(s) (b) <u>Chronic Endocarditis</u>			
Diseases or conditions, If any, giving rise to the above cause stating the underlying cause last (c) <u>General Arteriosclerosis</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 5-15, 1949, to 4-2, 1951, that I last saw the deceased alive on 4-2, 1951, and that death occurred at 8:15 P.m., from the causes and on the date stated above.

SIGNATURE James P. Sands, M.D. (Degree or title) ADDRESS Fauvel Sanitarium Fauvel, Md. DATE SIGNED 4-2-1951

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>4/6/51</u>	NAME OF CEMETERY OR CREMATORY <u>Homewood Cemetery</u>	LOCATION (City, town, or county) <u>Pittsburg, Pennsylvania</u>	(State)
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>Apr 3-1951</u>		24. FUNERAL DIRECTOR <u>W. W. Donaldson</u>		ADDRESS <u>Fauvel, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04022

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince George
 City or town Takoma Park
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 1/2 yrs
 Hospital, institution, or street address where death occurred:
7302 Trescott Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Prince George
 City or town Takoma Park
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 7302 Trescott Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Leo. William. Molitor

3. (b) Social Security Number

577 10 4536

4. Sex Male 5. Color of face White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Julia Ernestine Molitor
 7. Birth date of deceased (mo., day, yr.) Oct 18, 1878 6.(c) If alive, give age years

8. AGE: Years 72 Months 5 Days 26 It less than one day hrs. min.

9. Birthplace Cleveland Ohio 447X
 (Town, county, and state)

10. Usual occupation Waiter 97

11. Industry or business Restaurant

12. Name William Molitor

13. Birthplace Germany

14. Maiden name Pauline Stamber

15. Birthplace Germany

16. Informant Julia E. Molitor

Address 7302 Trescott, Takoma Park Md

17. Burial Date thereof April 16, 1951
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Lincoln Cemetery

Location Bladesburg Rd. Pr. Geo. County Md.

18. Funeral director J. Arthur Halthus

Address 254 Canoe St. NW. Washington, DC

April 17 1951 James Sever
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 14 1951 at 10:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/21/51 1935 to Apr 14 1951
 and that I last saw him alive on Apr 14 1951

Immediate cause of death Hypostatic pneumonia

Due to Uremia

Due to pericarditis chronic - hypertensia

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work? 784674

23. SIGNATURE James Sever M. D. or other
 Address Takoma Park, Md Date signed 4/14/51

RECEIVED

APR 18 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Prince Geo</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RENILWORTH JUNCTION</u> / MONTH <u>1</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>4612 R. St. N.E.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4612 R-ST. NE.</u>		STREET ADDRESS (If rural, give location) <u>Renilworth</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>ANGELINA J. MONACO</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>APRIL 1 1951</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>MAR-17-1878</u>
9. AGE last birthday <u>73</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Italy</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LAWRENCE D'ONOFRIO</u>		14. MOTHER'S MAIDEN NAME <u>MADELINE TARTAGLIA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give year or date of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT <u>MARY V. SOPER (DAUGHTER)</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Coronary artery heart disease</u>		
420.1 Antecedent cause(s)	(b) <u>Congestive heart failure</u>		
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) <u>Arteriosclerosis</u>		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1947, to April, 1951, that I last saw the deceased alive on April 1, 1951, and that death occurred at 11:10 m., from the causes and on the date stated above.

SIGNATURE <u>Robert B. Jurey</u>	(Degree or title)	ADDRESS <u>1833 Monroe St. N.E.</u>	DATE SIGNED <u>April 2, 1951</u>
23. BURIAL, CREMATION REMOVAL (Specify)	DATE <u>4/5/51</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>
DATE REC'D BY LOCAL REG. <u>Apr. 3, 1951</u>	REGISTRAR'S SIGNATURE <u>Carrie J. Campbell</u>	24. FUNERAL DIRECTOR <u>W.W. Chambers Co.</u>	ADDRESS <u>517 11th St SE</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 8 1951
BUREAU Y. 3

VS. AFR
H

CELL

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. STREET ADDRESS 4815- Clarke St E		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE D.C. b. COUNTY Washington	
b. FULL NAME OF HOSPITAL OR INSTITUTION HEALTH DEPT. D. PERMIT OFFICE		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Washington D.C.	
c. LENGTH OF STAY IN HOSPITAL IN D.C.		d. STREET ADDRESS (If rural, give location) 4815- Clarke St E	
3. NAME OF DECEASED (Type or Print) John H. Newcome		4. DATE OF DEATH (Month) (Day) (Year) April 5, 1951	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 10-38-1894
9. AGE (In years last birthday) 56		10. DATE OF BIRTH 10-38-1894	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY	
11a. BIRTHPLACE (State or foreign country) Pa		11b. CITIZEN OF WHAT COUNTRY? U.S.	
12. NAME OF SURVIVING SPOUSE Bertrude A		13. FATHER'S NAME John J. Newcome	
14. MOTHER'S MAIDEN NAME Mary M. Thomas		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY No. 578-07-4079		17a. INFORMANT Bertrude A Newcome	
17b. RELATED TO DECEDENT AS Wife		18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) 163X Carcinoma, Lung	
II. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to the death but not related to the disease or condition causing death. (Include report of pregnancy within 3 months of death))		INTERVAL BETWEEN ONSET AND DEATH 2 yr	
19a. DATE OF OPERATION 3-18-49	19b. MAJOR FINDINGS OF OPERATION Carcinoma, Lung	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. AUTOPSY FINDINGS
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended, the deceased from 4-23 , 19 49 , to 4-5 , 19 51 , and last saw him alive on 4-3 , 19 51 , and that death occurred at 8:30 a.m., from the causes and on the date stated above.			
23a. SIGNATURE Frank J. Pellegrini		23b. ADDRESS 3409 Ala Ave SE	
24a. BURIAL CREMATION REMOVAL <input type="checkbox"/>		24b. DATE 4/7/51	
24c. NAME OF CEMETERY OR CREMATORY Sedan Hill		24d. LOCATION (City, town, or county) (State) Switland Md	
D. C. Funeral Director's or Embalmer's License Number 258		24e. FUNERAL DIRECTOR John A. Whittington	
		ADDRESS 131-11 St E	

NOT PRIMA FACIE EVIDENCE.

CERTIFICATE FORWARDED TO US BY THE
GOVERNMENT OF THE DISTRICT OF COLUMBIA
HEALTH DEPARTMENT ON 4/7/53, mmb

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 232

1. PLACE OF DEATH- COUNTY <u>Prince Geo</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>P.G.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Queen Anne</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Queen Anne</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Upper Marlboro, Md</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Helen</u>	(Middle) <u>Beatrice</u>	(Last) <u>Newman</u>
4. DATE OF DEATH	(Month) <u>April</u>	(Day) <u>16</u>	(Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>28 July 1924</u>
9. AGE last birthday <u>26</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>James Maurice</u>	14. MOTHER'S MAIDEN NAME <u>Helen Pearl Windsor</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY No.	17. INFORMANT <u>Morris Windsor</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cardiac Decompensation

INTERVAL BETWEEN ONSET AND DEATH

1 max

Antecedent cause(s)

(b)

Hypertensive CV. diseaseUnknown

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.AsthmaUnknown

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Mar, 1937, to Apr, 1951, that I last saw the deceased alive on 14 Apr, 1951, and that death occurred at 8:45 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>4/19/51</u>	<u>Mt. Carmel</u>	<u>Upper Marlboro</u>	<u>Md.</u>

DATE RECD BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>April 18, 1951</u>	<u>[Signature]</u>	<u>Ritchie Bros.</u>	<u>Upper Marlboro, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE MAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

75

RECEIVED
APR 20 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

04025

Reg. Dist. No. 231

1. PLACE OF DEATH- COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE _____ COUNTY _____	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Hill</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
TOWN <u>Cherry Hill</u>		TOWN <u>Washington, D.C.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince Georges Gen. Hosp</u>		STREET ADDRESS (If rural, give location) <u>4549-44th St., N.W.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>John B. Nicholson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 10 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 19, 1904</u>
9. AGE last birthday <u>47</u> yrs.		10. If under 1 year: Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clifford Nicholson</u>		14. MOTHER'S MAIDEN NAME <u>Margie E. Lucas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT AND ADDRESS <u>Mildred G. Nicholson, Wife Same</u>			

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
420.1 Immediate cause (a) <u>Coronary Occlusion</u>	INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
131a Antecedent cause(s) (b) <u>Arteriosclerotic renal disease</u>	
(c) _____	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY _____ m.	INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR? _____

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE (Degree or title) John W. Maloney, M.D., Dep. Med. Exam. ADDRESS Cherry Hill, Hyattsville, Md. DATE SIGNED 4-10-51

23. BURIAL, CREMATION REMOVAL (Specify) Removal DATE THEREOF 10 April 1951 NAME OF CEMETERY OR CREMATORY Burial Home LOCATION (City, town, or county) (State) Bethesda Montgomery Md.

DATE REC'D BY LOCAL REG. 4/10/51 REGISTRAR'S SIGNATURE Amanda Downey 24. FUNERAL DIRECTOR B. Sachs Sons ADDRESS Hyattsville, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 12 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

04026

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> TOWN <u>70 days</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince George Gen. Hosp.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Prince George</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>East Riverdale</u> TOWN <u>4517 - Bowhatan Rd.</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Jos. L.</u> (Middle) <u>Norton</u> (Last) <u>Norton</u>	4. DATE OF DEATH (Month) <u>Apr</u> (Day) <u>11</u> (Year) <u>1951</u>	5. SEX <u>male</u>	6. COLOR OR RACE <u>W.</u>
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Apr. 277</u>	9. AGE last birthday <u>74</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician Retired</u>
11. BIRTHPLACE (State or foreign country) <u>unknown</u>	12. CITIZEN OF WHAT COUNTRY? <u>unknown</u>	13. FATHER'S NAME <u>unknown</u>	14. MOTHER'S MAIDEN NAME <u>unknown</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS <u>Annette V. Norton - wife</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Carcinomatous

INTERVAL BETWEEN ONSET AND DEATH

3 mo

Antecedent cause(s)

(b)

Probably primary in colon.

1 yr.

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1-31, 1951, to 4-11, 1951, that I last saw the deceased

alive on 4-11, 1951, and that death occurred at 448 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

BURIAL 4/13/51 Respect Hill Cem. Washington D.C.
4/11/51 Amanda Downes Timothy Danton 641 H. St. NE.

515 586

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 16 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

04027

Reg. Dist. No. 234

1. PLACE OF DEATH - COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Washington, D.C.</u> COUNTY <u>D.C.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fort Fort</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
TOWN <u>Potomac River</u>		TOWN <u>Washington, D.C.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Potomac River</u>		STREET ADDRESS <u>4311-1 Royal St., S.E.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Arthur</u> (Middle) <u>Young</u> (Last) <u>Oakley</u>		4. DATE OF DEATH (Month) <u>4</u> (Day) <u>11</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 13, 1923</u>
9. AGE last birthday <u>27</u> yrs.		10. If under 1 year: Months <u>4</u> Days <u>11</u> Hours <u>27</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>	
11. BIRTHPLACE (State or foreign country) <u>Rocky Mount, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Oakley</u>		14. MOTHER'S MAIDEN NAME <u>Alma Hedgereth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>World War 2</u>		16. SOCIAL SECURITY No. <u>243-20-4786</u>	
17. INFORMANT <u>Mrs. Arthur Oakley - Wife</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
566.8 Immediate cause (a) <u>Asphyxia</u>			
173 Antecedent cause(s) (b) <u>Drowning</u>			
Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c) <u>Airplane crashed into Potomac River</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, or other building, etc.) <u>Potomac River</u> (CITY OR TOWN) <u>Fort Fort</u> (COUNTY) <u>P. Geo - Md.</u> (STATE) <u>D.C.</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>4-7-51 5:00 P.M.</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> HOW DID INJURY OCCUR? <u>airplane piloted by deceased crashed into Potomac River</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>John D. Maloney, M.D., Dep. Med. Exam.</u>		ADDRESS <u>Charley Huttonville, Md.</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>		DATE THEREOF <u>12 April 51</u>	
NAME OF CEMETERY OR MEMORIAL <u>Johnson Funeral Home</u>		LOCATION (City, town, or county) <u>Rocky Mount, N.C.</u>	
DATE REC'D BY LOCAL REG. <u>4/11/51</u>		REGISTRAR'S SIGNATURE <u>Charles Huttonville</u>	
24. FUNERAL DIRECTOR <u>J. D. Dorsch, Sons</u>		ADDRESS <u>Hyattsville, Md.</u>	

Mrs. Ellen Davis

564.556

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 23 1951
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

04028

1. PLACE OF DEATH COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE D.C. COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Glenn Dale (Rural)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenn Dale Sanatorium		STREET ADDRESS 2509- 17 th , N.W.	
3. NAME OF DECEASED (Type or Print) JAMES (First) (Middle) (Last) PAGAN		4. DATE OF DEATH (Month) 4 (Day) 22 (Year) 1951	
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) married	8. DATE OF BIRTH 3-13-13
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY -	9. AGE last birthday 38 yrs.
11. BIRTHPLACE (State or foreign country) Gastonia, N. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jack Pagan		14. MOTHER'S MAIDEN NAME Sally Watson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 578-12-8580	
17. INFORMANT AND ADDRESS Decedent			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Pulmonary Tuberculosis

INTERVAL BETWEEN ONSET AND DEATH

Dys 3 mos

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 11/2 1949 to 4/22 1951, that I last saw the deceased

alive on 4/22 1951, and that death occurred at 11:10 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

Glenn Dale Sanatorium

DATE SIGNED

Glenn Dale, Md.

4/23/51

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
4/27/51	Wood Lane	Washington	D.C.	
DATE REC'D BY LOCAL REG. 4/23/51	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
	Wolfe	H. H. Norton & Co	1322 4 St NW	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

T

770000

RECEIVED
APR 30 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Landover Md</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Landover Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>6417 Landover Road</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Elfrieda Hilda Pfeffer</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 1, 1951-T9</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>1/21/84</u>
9. AGE last birthday <u>67</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Albert M. Schrater</u>		14. MOTHER'S MAIDEN NAME <u>ANNA BRNDT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Geo & Francis Pfeffer Landover Md (sons)</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Hypertensive heart Disease

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-10, 1940, to 4-1, 1951, that I last saw the deceased

alive on 3-26, 1951, and that death occurred at 3-26 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

4/3/51

Amanda Souney

Francis Gasch's Sons Hyattsville Maryland

Francis Gasch's Sons Hyattsville Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

04030

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Prince George</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bettsville Md.</u> LENGTH OF STAY <u>8 Mon.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bowie Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Reed Home</u>		STREET ADDRESS <u>3 Ann</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>HALLIE</u>		4. DATE OF DEATH (Month), (Day) (Year) <u>PHipp</u> <u>April 5</u> 19 <u>51</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>7/27/1966</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>84</u> yrs. If under 1 year Months, Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Ruth Boswell, Seat Pleasant, Md.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Acute Congestive Heart Failure</u>		<u>10 days</u>	
Antecedent cause(s) (b) <u>Chemia</u>		<u>-</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Generalized Arteriosclerosis</u>		<u>-</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>27 Feb</u> , 19 <u>51</u> , to <u>APRIL</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>4-5</u> , 19 <u>51</u> , and that death occurred at <u>12:30</u> A.M., from the causes and on the date stated above.			
SIGNATURE <u>Dr. Etienne M.D.</u> (Degree or title)		ADDRESS <u>College Park, Md</u> DATE SIGNED <u>4-5-51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE <u>4/8/51</u> NAME OF CEMETERY OR CREMATORY <u>MT. OAKS CEMETARY</u> LOCATION (City, town, or county) (State) <u>Mitchellville, Md.</u>	
DATE REC'D BY LOCAL REG. <u>4/7/51</u>		24. FUNERAL DIRECTOR <u>J. J. Sasso Sons Hyattsville, Md.</u>	
REGISTRAR'S SIGNATURE <u>John D Smith</u>			

I MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 12 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04031

Reg. Dist. No. 243

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (Rural)</u> TOWN <u>Glenn Dale (Rural)</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Glenn Dale Sanatorium</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>D. C.</u> COUNTY <u>-</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> TOWN <u>Washington</u> STREET ADDRESS (If rural, give location) <u>1514 3rd St., N. W.</u>															
3. NAME OF DECEASED (Type or Print) <u>LOLA</u> (First) <u>E</u> (Middle) <u>PIERCE</u> (Last)		4. DATE OF DEATH (Month) <u>4th</u> (Day) <u>11</u> (Year) <u>1951</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>4/12/1914</u>		9. AGE last birthday <u>36</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		11. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Widowed</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>				11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Henry Beall</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ida Dockett</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-</u>				16. SOCIAL SECURITY No. <u>Unknown</u>				17. INFORMANT AND ADDRESS <u>Decedent</u>			
18. MEDICAL CERTIFICATION																			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH														INTERVAL BETWEEN ONSET AND DEATH					
Immediate cause (a) <u>Pulmonary Tuberculosis</u>														3 mos					
Antecedent cause(s) (b) <u>002X 130 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>																			
(c)																			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.																			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION								20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)				PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY				(CITY OR TOWN)				(COUNTY) (STATE)							
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>				HOW DID INJURY OCCUR?											
22. I hereby certify that I attended the deceased from <u>3/19</u> , 19 <u>51</u> , to <u>4/11</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>4/10</u> , 19 <u>51</u> , and that death occurred at <u>1205a</u> m., from the causes and on the date stated above.																			
SIGNATURE <u>Daniel P. Pinciano</u>				(Degree or title) <u>M. D.</u>				ADDRESS <u>Glenn Dale Sanatorium</u>				DATE SIGNED <u>4/11/51</u>							
23. BURIAL, CREMATION, REMOVAL (Specify)				DATE THEREOF <u>4/14/51</u>				NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>				LOCATION (City, town, or county) <u>Washington D.C.</u> (State) <u>D.C.</u>							
DATE REC'D BY LOCAL REG. <u>4/11/51</u>				REGISTRAR'S SIGNATURE <u>Woe Weiss</u>				24. FUNERAL DIRECTOR <u>A. J. Lopez</u>				ADDRESS <u>www</u>							

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 18 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *245*

04032

1. PLACE OF DEATH - COUNTY Prince Georges County MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE Maryland Prince Georges	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Riverdale Hills Md		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Riverdale Hills Md	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 6409 63 place		STREET ADDRESS (If rural, give location) 6409 63 place	
3. NAME OF DECEASED (Type or Print) Rose Mary Prowinsky		4. DATE OF DEATH April 16, 1951	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH 8/23/1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coast U. S. Geodetic		10b. KIND OF BUSINESS OR INDUSTRY U. S. Government	9. AGE last birthday 57 yrs.
11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME August Prowinsky		14. MOTHER'S MAIDEN NAME Mary Manlei	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) ---		16. SOCIAL SECURITY No. ---	
17. INFORMANT AND ADDRESS Gertrude P Upezak Riverdale Hills Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause 15 IX Antecedent cause(s)	(a) Generalized Carcinomatous - G of Lung	4 months
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma of Stomach	18 months
(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION 2-12-51	19b. MAJOR FINDINGS OF OPERATION Mucinous Carcinoma of Stomach with metastases	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 20, 1951, to April 16, 1951, that I last saw the deceased alive on April 6, 1951, and that death occurred at 10 1/2 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 20 1951

BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH- COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale (East Pines)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince Georges Gen. Hosp.</u>		STREET ADDRESS <u>6033--67th Place</u>	
3. NAME OF DECEASED (Type or Print) <u>James</u> (First) <u>Joseph</u> (Middle) <u>Quinn</u> (Last)		4. DATE OF DEATH <u>April</u> (Month) <u>13th</u> (Day) <u>1951</u> (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 13/1882</u>
9. AGE last birthday <u>69</u> yrs.		10. If under 24 hrs. Months. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boiler Maker (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US Navy Yard</u>	
11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>James A. Quinn 6033-67th Pl. E. Riverdale</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Pulmonary Hemorrhage.</u>	Antecedent cause(s) (b) <u>Carcinoma of Lung</u>	Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Prostatic Uleer.</u>	<u>1 day.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			<u>6 months</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>HOMICIDE</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/13/51, 1951, to 4/13/51, 1951, that I last saw the deceased alive on 4/13/51, 1951 and that death occurred at 10:50 P.m., from the causes and on the date stated above.

SIGNATURE <u>Albert Roth</u>	(Degree or title) <u>M.D.</u>	ADDRESS <u>5007 Woodson St. Riverdale Md</u>	DATE SIGNED <u>4/14/51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>4/17/1951</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
DATE REC'D BY LOCAL REG. <u>4-14-51</u>	REGISTRAR'S SIGNATURE <u>Amanda Courtney</u>	24. FUNERAL DIRECTOR <u>W.W. Chambers Company, Riverdale, Md.</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 415-1

503716

RECEIVED

APR 17 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 239

04034

1. PLACE OF DEATH CITY OR TOWN <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>PRINCE GEORGE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Laurel P.F.D</u>		STREET ADDRESS (If rural, give location) <u>near Laurel</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>REBECCA</u>	<u>Frances</u>	<u>RAU</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Sept 22, 1881</u>
			9. AGE last birthday <u>69</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Woodstock Va</u>
13. FATHER'S NAME <u>Anderson H Bolt</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No. <u>None</u>	17. INFORMANT AND ADDRESS <u>Sean Campbell</u> <u>Oak Crest</u>

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Lobar Pneumonia

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Fracture hip - gangrene foot
(c) Dissecting

INTERVAL BETWEEN ONSET AND DEATH

2 days4 mo.9 yr.II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-23, 1950, to 4-27, 1951, that I last saw the deceasedalive on 4-27, 1951, and that death occurred at 4 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>April 30, 1951</u>	<u>Fairview</u>	<u>near Woodstock</u>	<u>MD</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>April 28-51</u>	<u>M. Beashear</u>	<u>Rede Corp</u>	<u>Laurel</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A45

RECEIVED
MAY 1 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04035

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Prince Georges'</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Pr. Geo</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural (Upper Marlboro)</u> 8 years		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural (Upper Marlboro)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>Albert</u>	<u>Zearl</u>	<u>Ringer</u>	
4. DATE OF DEATH	(Month)	(Day)	(Year)
<u>4</u>	<u>5</u>	<u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Mar. 8, 1886</u>
9. AGE last birthday <u>65</u> yrs.		10. If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painting</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>landyman laborer</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Ringer</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes.</u> (If yes, give war or dates of service) <u>W.W.</u>		16. SOCIAL SECURITY No. <u> </u>	
17. INFORMANT AND ADDRESS <u>Mrs. Regina Ringer-Upper Marlboro?</u>		<u>Md</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <u>Coronary Thrombosis</u>			<u>5 min</u>
Antecedent cause(s) (b) <u>Arteriosclerotic CV disease</u>			<u>unk</u>
93d Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	
(CITY OR TOWN)		(COUNTY)	
(STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3 Apr</u> , 19 <u>51</u> , to <u>5 Apr</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>4 Apr</u> , 19 <u>51</u> , and that death occurred at <u>6:30 A</u> . m., from the causes and on the date stated above.			
SIGNATURE <u>Robert B. Casser</u>		ADDRESS <u>Upper Marlboro</u>	
DATE SIGNED <u>5 Apr 1951</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		DATE THEREOF <u>4/9/51</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Peters Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>APR 9 1951</u>		REGISTRAR'S SIGNATURE <u>L</u>	
24. FUNERAL DIRECTOR <u>Wm. Gork. Inc.</u>		ADDRESS <u>1217 St. Paul Street</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A151

564246

MARYLAND STATE DEPARTMENT OF HEALTH

04036

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 241

1. PLACE OF DEATH COUNTY Prince Georges MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Fairmont Heights HOSPITAL OR INSTITUTION OR STREET ADDRESS 6110 S. Street		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Prince Georges CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Fairmont Heights STREET ADDRESS (If rural, give location) 6110 S. Street	
3. NAME OF DECEASED (Type or Print) William Albert Seldon		4. DATE OF DEATH (Month) (Day) (Year) 4-25 1951	
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Sept 22, 1933
9. AGE last birthday 17 yrs.		10. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student b. KIND OF BUSINESS OR INDUSTRY High School	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME William Seldon		14. MOTHER'S MAIDEN NAME Carida Hunt.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT William Seldon.		Father	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Dementia

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Meningococcal meningitis (Waterhouse-Friedenreich syndrome).

(c) House - Friedenreich syndrome.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF Apr 26/51		NAME OF CEMETERY OR CREMATORY Lincoln Memorial		LOCATION (City, town, or county) Hyattsville Md		(State)
DATE REC'D BY LOCAL REG. Apr 26/51		REGISTRAR'S SIGNATURE Carrie J. Campbell		24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville Md		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

14
2
3631

RECEIVED

MAY 1 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04037
245

1. PLACE OF DEATH- COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Prince George</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>	
TOWN		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <u>3817-37th St.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>WILLIAM I SHIELDS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 29 1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan 31-1891</u>
9. AGE last birthday <u>62</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>	11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Peter Shields</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Thornton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
		17. INFORMANT <u>Marguerite Shields</u>	

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
(a) Immediate cause <u>Acute Pulmonary Insufficiency</u>			<u>1 day</u>
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Metastatic Disease</u>			<u>4 months</u>
(c) <u>Bronchogenic Carcinoma Rt</u>			<u>7 months</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Bronchogenic Carcinoma</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov, 1950, to April, 1951, that I last saw the deceased alive on April 28, 1951, and that death occurred at 3 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Benjamin S. MillerM.D.3824-34 ST Mt. RainierApril 29 1951

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>burial</u>	<u>May 2nd 1951</u>	<u>Mt. Albert Cemetery</u>	<u>Wash. D.C.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>April 29 1951</u>	<u>James Leroy</u>	<u>J. F. Costello</u>	<u>Wash. D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 2 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH: COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>md</u> COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> LENGTH OF STAY (in this place) <u>30 yr</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> OR TOWN <u>md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4211 Greenbury Rd</u>		STREET ADDRESS (If rural, give location) <u>4211 Greenbury Rd</u>	
3. NAME OF DECEASED (Type or Print) <u>WILLARD AARON SIMONDS</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>18</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>May 20 - 1871</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Photographer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>	9. AGE last birthday <u>74</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Merndon Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edwin B Simons</u>		14. MOTHER'S MAIDEN NAME <u>Marion Earnham</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT <u>Betha M. Simons Hyattsville Rd</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Myocardial failure

INTERVAL BETWEEN ONSET AND DEATH

2 days

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

Carcinoma of colon8 months

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

8-7-50anastomotic carcinoma ascending colon

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-4-50, 19....., to 8, 19....., that I last saw the deceasedalive on....., 19....., and that death occurred at 4:30 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Apr 19 1951 James SeverF. Pasche some Hyattsville014916 md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 20 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

04039

Reg. Dist. No. 242

1. PLACE OF DEATH- COUNTY <u>Prince Georges</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chapel Oaks</u> LENGTH OF STAY (in this place) <u>5 mos</u> TOWN <u>Chapel Oaks</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5712 Addison Chapel Rd</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Pr. Geo</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chapel Oaks</u> TOWN <u>Chapel Oaks</u> STREET ADDRESS (If rural, give location) <u>5712 Addison Chapel Rd</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Kenneth Stanley Smith</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Apr. 30 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Nov. 13, 1950</u>
9. AGE last birthday <u>6</u> yrs. If under 1 year Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	
10a. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>Levi Smith</u>	
14. MOTHER'S MAIDEN NAME <u>Glorie Martin</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY No. <u>none</u>		17. INFORMANT <u>Levi Smith - Father</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Asphyxia

Antecedent cause(s) (b) Aspiration of food

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>1 May 5</u>	<u>Methodist Cemetery</u>	<u>Bladenburg, Maryland</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
<u>5-1-57</u>	<u>Carrie J. Campbell</u>	<u>Harold's Sons Hyattsville, Md.</u>		

20X130282

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED

MAY 7 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

04040

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 245

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Purcellville, Md</u> TOWN <u>8 1/2 hrs</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Seland Memorial Hosp</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Prince George</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> TOWN <u>Hyattsville</u> STREET ADDRESS (If rural, give location) <u>7203 Forest Road, Kent Village</u>	
3. NAME OF DECEASED (Type or Print) <u>Sue Ellen Smith</u>		4. DATE OF DEATH (Month) <u>4</u> (Day) <u>27</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Oct. 3, 1946</u>
9. AGE last birthday <u>4</u> yrs.		10. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Kenon, Wash.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Cecil Charles Smith</u>		14. MOTHER'S MAIDEN NAME <u>Eun Rose Pinkerton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Hospital records</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

510.1 Immediate cause (a) Congestive heart failure

115c Antecedent cause(s) (b) Shock -

(c) Operation under ether for tonsillectomy

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office, etc.) OF INJURY <u>Hospital</u>	(CITY OR TOWN) <u>Purcellville, Pr. George, Md.</u>	(COUNTY) <u>Prince George</u>	(STATE) <u>Md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>4-27-51 9:00 A.M.</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>Operation under ether. Collapsed - Continued to be revived.</u>		

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL, ETC.	DATE THEREOF <u>4/29/51</u>	NAME OF CEMETERY OR CREMATORY <u>Hammons Funeral Home</u>	LOCATION (City, town, or county) <u>Littlefield Texas</u>	(State) <u>Texas</u>
DATE REC'D BY LOCAL REG. <u>April 28 1951</u>	REGISTRAR'S SIGNATURE <u>James S. Gray</u>	24. FUNERAL DIRECTOR <u>F. Basela Sr. Hyattsville Md</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 2 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 231

04041

1. PLACE OF DEATH: COUNTY <u>Prince Georges</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Morningside</u> TOWN <u>Morningside</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>302 Poplars Road.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Prince Georges</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Morningside</u> TOWN <u>Morningside</u> STREET ADDRESS (If rural, give location) <u>302 Poplars Road.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Ida</u> <u>Smnyder</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>4-8</u> <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Nov. 23, 1911</u>
9. AGE last birthday <u>6</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Nebraska</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Russell Snyder, Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Dorothea Gardner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Military Records of father</u>	

17. INFORMANT AND ADDRESS <u>Military Records of father</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause <u>Shock</u>		(a) <u>Shock</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(b) <u>3rd & 4th degree burns of body</u>	
		(c) <u>Conflagration in home</u>	
2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>4-8-51 4:05 P.M.</u>		PLACE (Home, farm, factory, street, office bldg, etc.) OF INJURY <u>Home</u> INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		(CITY OR TOWN) (COUNTY) (STATE) <u>Morningside - P. Geo. County, Md.</u>	
				HOW DID INJURY OCCUR? <u>P. 29 - crashed into home causing conflagration & destruction</u>	

22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
SIGNATURE <u>John D. Malone, M.D., Dep. Med. Exam.</u>		(Degree or title)		ADDRESS <u>Cheverly - Hyattsville, Md.</u>	
DATE SIGNED <u>4-9-51</u>					
23. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>		DATE THEREOF <u>4/9/51</u>		NAME OF CEMETERY OR CREMATORY <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR <u>Wastler Funeral Home, Wash. D.C.</u>		ADDRESS <u>Washington, D.C.</u>			

Sign Here also

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 26 1968
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 04042
231

1. PLACE OF DEATH COUNTY Prince Georges MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Morningside 2 mps. HOSPITAL OR INSTITUTION OR STREET ADDRESS 302 Poplars Road.		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Prince Georges CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Morningside STREET ADDRESS (If rural, give location) 302 Poplars Road.	
3. NAME OF DECEASED (Type or Print) (First) Rene (Middle) Denise (Last) Snyder		4. DATE OF DEATH (Month) 4 (Day) 8 (Year) 1951	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Feb. 9, 1951
9. AGE last birthday yrs. 2		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Roswell Snyder, Jr.		14. MOTHER'S MAIDEN NAME Dorothy Gardner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Military records of father.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Hemorrhage & shock

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Multiple dismembering of body.

(c) Struck by airplane crashing into home.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Home

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY 4-8-51 4:05 p.m.

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? U.S. B-25 crashed into home of deceased causing injury & destruction

20. AUTOPSY?

Yes ☐ No ☒

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG. 4/9/51

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

2-0-2-091-37-4-36-4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16A

RECEIVED

APR 26 1951

BUREAU V. S.

MARGIN RESERVED FOR BINDING

VS. A157

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of 10,13,14,17, shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04043

FILM NO. G 1 APR 16 1951 CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cottage City</u>	
TOWN <u>Chesley</u>		TOWN <u>Cottage City</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince Georges Hospital</u>		STREET ADDRESS (If rural, give location) <u>4100 Cottage Terrace</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Joseph</u> (Middle) <u>W.</u> (Last) <u>Saper</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>10</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M.</u>	8. DATE OF BIRTH <u>Jan 21 1861</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	9. AGE last birthday <u>90</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
13. FATHER'S NAME <u>Otto Saper</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>Eliabert ??</u>	
16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS (Son) <u>Wm. H. Saper - 4100 Cottage Terrace</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Auricular Fibrillation

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arterio-sclerotic of left lower extremity.

(c) Embolism (cardiac)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Mar 16, 1951, to Apr 10 1951, that I last saw the deceased alive on Apr 10, 1951, and that death occurred at 7:30 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>4-13-51</u>	<u>Wash. Nat.</u>	<u>Suitland Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>4-10-1951</u>	<u>Amanda Woron</u>	<u>W. W. Chambers Co.</u>	<u>517-11 St. St.</u>	

570246 S.E. D.C.

RECEIVED
APR 12 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 242

04044

1. PLACE OF DEATH- COUNTY <u>Prince George County</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Prince George</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hillside</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hillside</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Residence</u>		STREET ADDRESS (If rural, give location) <u>1404 57th Avenue</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>ELIZABETH GORDON SWANSON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 18, 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 15, 1862</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife, Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	9. AGE last birthday <u>89</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Gordon</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Swanson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Agnes Smith, 405 57th Ave, Cap. Hgts. Md.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause 331X Antecedent cause(s) 83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(a) <u>C. C. C.</u> <u>Coronary or Cerebral accident, acute</u> (b) <u>Generalized arteriosclerosis</u> (c) <u>None</u>	<u>10 minutes</u> <u>5 years</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from February, 1951, to April 18, 1951, that I last saw the deceased alive on April 8, 1951, and that death occurred at 5:20 P.M., from the causes and on the date stated above.

SIGNATURE <u>Emmet E. Cornelsen, MD</u>		ADDRESS <u>4400 Bowen Rd. SE. Wash. D.C.</u>		DATE SIGNED <u>4/18/51</u>
23. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE <u>April 21, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>TRINITY CEMETERY</u>	LOCATION (City, town, or county) (State) <u>UPPER MARLBORO, M.D.</u>	
DATE REC'D BY LOCAL REG. <u>April 21, 1951</u>		REGISTRAR'S SIGNATURE <u>Carrie F. Campbell</u>		24. FUNERAL DIRECTOR <u>W. W. CHAMBERS CO., 517 11th St., S.E.</u>

Signed with consent of County Coroner

Wash., D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 237

04845

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Virginia</u> COUNTY <u>Accomack</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Tauvel</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Onancock</u>	
TOWN <u>no</u>		TOWN <u>Onancock</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Tauvel Sanitarium</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>ROBERT</u> (First) <u>DIGHTON</u> (Middle) <u>TAYLOR</u> (Last)		4. DATE OF DEATH <u>April</u> (Month) <u>20</u> (Day) <u>1951</u> (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>- about 1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Lewis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO.	
(If year, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Robert D. Taylor (son) Onancock, Va.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Chronic Myocarditis</u>			<u>Many years</u>
422.1 Antecedent cause(s) (b) <u>Chronic Endocarditis</u>			" "
92d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>General Arteriosclerosis</u>			" "

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
21. ACUTE SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-30, 1950, to 4-20, 1951, that I last saw the deceased alive on 4-19, 1951, and that death occurred at 12:15 p.m., from the causes and on the date stated above.

SIGNATURE James P. Fauds, M.D. (Degree or title) Tauvel Sanitarium, Tauvel, Md. ADDRESS 4-20-1951 DATE SIGNED

23. BURIAL, CREMATION OR OTHER (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Funeral</u>	<u>4-22-51</u>	<u>Onancock</u>	<u>Onancock, Virginia</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS	
<u>4/20/51</u>	<u>A W Hedrick</u>	<u>Edward W. Steward 2503 Edmondson</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

04046

1. PLACE OF DEATH COUNTY <u>Prince Georges Co.,</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>D. C.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Glenn Dale (rural)</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Glenn Dale Tuberculosis Sanatorium.</u>		STREET ADDRESS <u>921 Third Street Northwest</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>MARY</u>	(Middle)	(Last) <u>THOMAS</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	4. DATE OF DEATH (Month) <u>4</u> (Day) <u>26</u> (Year) <u>1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	8. DATE OF BIRTH <u>3/9/1865</u>
13. FATHER'S NAME <u>William Thomas</u>		11. BIRTHPLACE (State or foreign country) <u>Prince William Co., Va.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
16. SOCIAL SECURITY No. <u>None</u>		14. MOTHER'S MAIDEN NAME <u>Mildred Penn</u>	
17. INFORMANT AND ADDRESS <u>Decedent</u>		17. INFORMANT AND ADDRESS	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Cerebral embolism</u>		<u>8 Days</u>
Antecedent cause(s) (b) <u>Arterio sclerotic heart disease</u>		<u>1 mo 2 weeks</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
<u>Pulmonary Tuberculosis</u>		<u>1 mo 2 weeks</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>4/2</u> , 19 <u>51</u> , to <u>4/26</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>4/26</u> , 19 <u>51</u> , and that death occurred at <u>4:15 a</u> .m., from the causes and on the date stated above.		
SIGNATURE <u>Daniel Leo Pinicare</u> M.D.		DATE SIGNED <u>4/26/51</u>
23. BURIAL, CREMATION, REMOVAL (Specify)		LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG. <u>4/26/51</u>	REGISTRAR'S SIGNATURE <u>Abel Weiss</u>	24. FUNERAL DIRECTOR <u>R.N. Horton & Co</u> ADDRESS <u>1322 4th St. NW</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

MAY 2 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

04047

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 245

1. PLACE OF DEATH: COUNTY <i>Prince Georges</i>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <i>Maryland</i> COUNTY <i>Pr. Geo.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Mt. Rainier</i>	
TOWN <i>Hyattsville</i>		TOWN <i>Mt. Rainier</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Selands Memorial Hosp</i>		STREET ADDRESS <i>3405 Newton St.</i>	
3. NAME OF DECEASED (First) (Middle) (Last) <i>Thomas Evan Thomas</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>April 24 1951</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Sept. 1874</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chief Controller</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Steel Rolling</i>	9. AGE last birthday <i>76</i> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <i>Great Britain (Wales)</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Theophilus Thomas</i>		14. MOTHER'S MAIDEN NAME <i>Mary Davies</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY No. <i>169-01-8185</i>	
17. INFORMANT <i>William Happel - Son-in-law</i>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) *Acute congestive heart failure*

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(b) *Coronary Thrombosis & sclerosis*(c) *Coronary Occlusion*

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Cardiovascular renal disease.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>4/27/1951</i>		NAME OF CEMETERY OR CREMATORY <i>Old Oak Grove Cemetery</i>		LOCATION (City, town, or county) (State) <i>Morgantown, West Virginia</i>	
DATE REC'D BY LOCAL REG <i>April 26, 1951</i>		REGISTRAR'S SIGNATURE <i>Mrs. Jas. Devere</i>		24. FUNERAL DIRECTOR <i>Nalley's Funeral Home</i>		ADDRESS <i>3200-R.I. Ave. Mt. Rainier, Md. 58133</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 27 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *MS*

1. PLACE OF DEATH COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Pr. Geo.	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Avondale		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Avondale	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 4810 Avondale Road		STREET ADDRESS (If rural, give location) 4810 Avondale Rd.	
3. NAME OF DECEASED (Type or Print)	(First) Charles (Middle) E. (Last) Thornburg	4. DATE OF DEATH (Month) April (Day) 16 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 9/23/1885
9. AGE last birthday 65 yrs.		10. If under 1 year Months 6 Days 23 Hours 23 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Engineer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Air Force	
11. BIRTHPLACE (State or foreign country) Beatrice, Nebraska		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John D. Thornburg		14. MOTHER'S MAIDEN NAME Mary Elizabeth Ford	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. John C. Thornburg 1506 Elson St. DC	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) *central embolus*

Antecedent cause(s)

(b) *post-rheumatic heart disease & congestive failure*(c) *congestive failure*

INTERVAL BETWEEN ONSET AND DEATH

*30 min**3 yrs*

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *June*, 19*48*, to *4/16/51*, that I last saw the deceasedalive on *4/9/51*, and that death occurred at *11:20 A.m.*, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

*April 19, 1951 John Severy**Nalley's Funeral Home 3200-R.I. Ave.**644916 Mt. Rainier, Md.*

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

APR 20 1951

BUREAU V. S.

04049

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. *245*

1. PLACE OF DEATH COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>N. Carolina</i> COUNTY <i>Lee</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Riversdale</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Sanford</i>	
TOWN <i>Riversdale</i>		TOWN <i>Sanford</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Leland Hospital</i>		STREET ADDRESS (If rural give location) <i>Sanford North Carolina</i>	
3. NAME OF DECEASED (Type or Print) <i>EMEREL</i> (First) <i>UPCHURCH</i> (Last)		4. DATE OF DEATH <i>April 7, 1957</i> (Month) (Day) (Year)	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>married</i>	8. DATE OF BIRTH <i>Nov. 11, 1926</i>
9. AGE last birthday <i>24</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>linesman</i>	
11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>Rupert Upchurch</i>		14. MOTHER'S MAIDEN NAME <i>Helen Belle</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY No. <i>11-11-11</i>	
17. INFORMANT <i>Betty Lill Upchurch-Jones</i>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) *Asphyxia*

Antecedent cause(s)

(b) *Electrocution*

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) *Contact with hot wire while at work*

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY *Street*

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY *9-7-51-12:13 P.m.*INJURY OCCURRED While at work ☒ Not while at work ☐

HOW DID INJURY OCCUR?

Contact with live wire while working on a pole

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

*April 7, 1957 James Sever**L. Gasche son Hyattsville Md*

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

690 VVV

RECEIVED

APR 10 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 245

04050

1. PLACE OF DEATH COUNTY <u>P. Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>P. Geo</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>	
TOWN <u>Laurel Memorial</u>		TOWN <u>Laurel</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Laurel Memorial</u>		STREET ADDRESS (If rural, give location) <u>611 Main St.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Henry James Vincent</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 12 1951</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 8, 1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>	9. AGE last birthday <u>70</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lawrence Vincent</u>		14. MOTHER'S MAIDEN NAME <u>Mary</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>159817400</u>	
17. INFORMANT AND ADDRESS <u>hosp. records.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Hypertensive Cardiovascular Disease 1 mo.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertension 1 yr.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 4-6, 1951, to 4-12, 1951, that I last saw the deceased alive on 4-11, 1951, and that death occurred at 11:15 a.m., from the causes and on the date stated above.

SIGNATURE L. Ellenberger, MD. ADDRESS Riverdale, Md. DATE SIGNED 4-12-51

23. BURIAL, CREMATION REMOVAL (Specify) DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)

Funeral 4/14/51 East Lincoln Cem. Washington DC.

DATE REC'D BY LOCAL REG. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS

April 13, 1951 James Sever De Witt Sanabean, Laurel, Md.

April 18, 1951

820105

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 242

04051

1. PLACE OF DEATH: COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Capitol Heights</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Capitol Heights</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6105 Kingston Road</u>		STREET ADDRESS (If rural, give location) <u>6105 Kingston Road</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>JOHN</u> <u>EDGAR</u> <u>WEAST</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April</u> <u>3</u> <u>1951</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>March 25, 1859</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Alexandria, Va.</u>
13. FATHER'S NAME <u>James Henry Weast</u>		14. MOTHER'S MAIDEN NAME <u>Anna Brook</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT <u>Grace W. Dove</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Congestive heart failure

INTERVAL BETWEEN ONSET AND DEATH

3 weeks

Antecedent cause(s)

(b)

Arteriosclerotic heart disease with

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

generalized arteriosclerosis15 years(?)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/11, 1951, to 4/3, 1951, that I last saw the deceasedalive on 4/3, 1951, and that death occurred at 10:07 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

William Brannin MD6124 Central Ave, Capitol Hgts Md4/6/51

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Apr. 4-1951Carrie K. CampbellW. W. Chambers Co. Wash. D.C.

510246

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 240

1. PLACE OF DEATH COUNTY <u>Prince Geo. Co.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Prince Geo.</u> COUNTY <u>Md.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cheltenham</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Isaac</u> (First) <u>W</u> (Middle) <u>West</u> (Last)		4. DATE OF DEATH (Month) <u>4</u> (Day) <u>18</u> (Year) <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>2-10-1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>tenant</u>	9. AGE last birthday <u>72</u> yrs.
13. FATHER'S NAME <u>Henry West</u>		11. BIRTHPLACE (State or foreign country) <u>Brandwine Md.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Betsy</u>	
16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <u>Andrew West</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary embolism</u>	Antecedent cause(s) (b) <u>cardiorenal disease</u>	<u>3 months</u>
(c) <u>arteriosclerosis + rheumatic fever</u>		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....m., from the causes and on the date stated above.

SIGNATURE Alfred R. Laper (Degree or title) MD. ADDRESS Clinton, Md. DATE SIGNED April 19, 1957

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>4/21/57</u>	<u>Gibson Cem.</u>	<u>Pr. Geo. Maryland</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>Apr 20-57</u>	<u>Carrie F. Campbell</u>	<u>Myrtle L. Rollins</u>	<u>4339 Hurl</u>

#264 100105 4'E

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 25 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

04053

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 242

1. PLACE OF DEATH COUNTY Prince Georges MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) LENGTH OF STAY (In this place) TOWN Llanwood Park 2 years HOSPITAL OR INSTITUTION OR STREET ADDRESS 1306-51st Ave		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Prince Georges CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Llanwood Park STREET ADDRESS (If rural give location) ADDRESS 1306-51st Ave	
3. NAME OF DECEASED (First) (Middle) (Last) Phyllis Elizabeth Whitty		4. DATE OF DEATH (Month) (Day) (Year) April 30 1957	
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH April 1, 1911
9. AGE last birthday 40 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Washington D.C.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME Walter M. Aber	
14. MOTHER'S MAIDEN NAME Ehrra Peyton		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY No. None		17. INFORMANT Percy Whitty - Husband	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) Cerebral compression		
Antecedent cause(s) (b) Subarachnoid hemorrhage		
Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c) Arterial hypertension		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE John D. Maloney, M.D. Dep. Med. Exam. - Cheverly, Md.		DATE SIGNED 4-30-57	
23. BURIAL, CREMATION OR REMOVAL (Specify) Burial	DATE THEREOF May 3, 1957	NAME OF CEMETERY OR CREMATORY Wayne Cemetery	LOCATION (City, town, or county) (State) Washington D.C.
DATE REC'D BY LOCAL REG. 5/1/57	REGISTRAR'S SIGNATURE Carrie J. Campbell	24. FUNERAL DIRECTOR Henry S. Washington & Sons	ADDRESS 467 N. ST. ALW

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 7 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

04054

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>D. C.</u> COUNTY <u>-</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Glenn Dale (Rural)</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Glenn Dale Sanatorium</u>		STREET ADDRESS (If rural, give location) <u>1225 1st St., N. W.</u>	
3. NAME OF DECEASED (Type or Print) <u>MATTIE</u> (First) <u>MAE</u> (Middle) <u>WIGFALL</u> (Last)		4. DATE OF DEATH (Month) <u>4</u> (Day) <u>23</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>6/21/1915</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10h. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE last birthday <u>35</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Aiken, S. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Tommie Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Janie Addison</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>577-30-8745</u>	
17. INFORMANT AND ADDRESS <u>Decedent</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Pulmonary Tuberculosis

INTERVAL BETWEEN ONSET AND DEATH

1 yr 5 mos

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 5/10, 1950, to 4/23, 1951, that I last saw the deceasedalive on 4/23, 1951, and that death occurred at 11:45 a.m., from the causes and on the date stated above,

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Glenn Dale Sanatorium</u>	<u>4/23/51</u>	<u>Glenn Dale, Maryland</u>	<u>Washington DC</u>	

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

4/23/51Alce WeirHenry S. Washington & Son467 11th St N.W.T.P.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 30 1951
BUREAU V. S.

CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

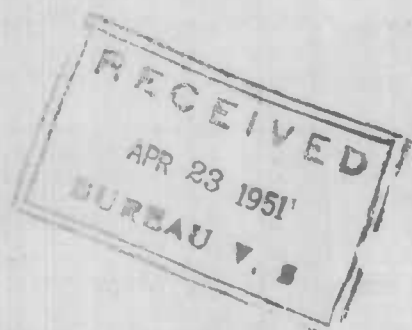
Reg. Dist. No. 251

PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH COUNTY <u>Prince Georges</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Hyattsville, P.O.</u>		LENGTH OF STAY (In this place) <u>1 year</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Hyattsville, P.O. (Bladensburg)</u>	
TOWN <u>Hyattsville, P.O.</u>				STREET ADDRESS <u>5645 Annapolis Road</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5645 Annapolis Road</u>					
3. NAME OF DECEASED (Type or Print) <u>Nell</u>		(First) <u>William</u>		(Last) <u>Williams</u>	
4. DATE OF DEATH <u>April 18 1951</u>		(Month) <u>April</u>		(Day) <u>18</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	
8. DATE OF BIRTH <u>Sept. 21/1905</u>		9. AGE last birthday <u>45</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Bourg, La</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Augustine Jarreau</u>	
14. MOTHER'S MAIDEN NAME <u>Therian Champagne</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Otha Williams, Son - Husband</u>		18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH	
(a) <u>Acute congestive heart failure</u>					
(b) <u>Antecedent cause(s)</u>					
(c) <u>Disease or conditions, if any, giving rise to the above cause stating the underlying cause last</u>					
II. OTHER SIGNIFICANT CONDITIONS					
Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input checked="" type="checkbox"/> .					
SIGNATURE		(Degree or title)		ADDRESS	
<u>John J. Malone, M.D., Dep. Med. Exam. - Hyattsville, Md.</u>		<u>4-19-51</u>		<u>4-19-51</u>	
23. BURIAL, CREMATION OR REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATOR	
<u>Burial</u>		<u>4/20/51</u>		<u>Lincoln Cemetery</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
<u>4/20/51</u>		<u>Amanda Dourney</u>		<u>E. Saschewski Hyattsville Md</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

04056

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Waldorf</u> COUNTY <u>Charles Co. Md</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington 30 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf - Charles Co. Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7841 Loring Road Washington 30 DC</u>		STREET ADDRESS (If rural, give location) <u>none</u>	
3. NAME OF DECEASED (First) <u>Luce</u> (Middle) <u>Taylor</u> (Last) <u>Williams</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>14</u> (Year) <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Feb 10 1870</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	9. AGE last birthday <u>81</u> yrs. If under 1 year Months Days If under 24 hrs Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Charles Co. Md</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>unknown Taylor</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Samuel Williams 7841 Loring Road Washington 30 DC</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Acute Coronary Occlusion

INTERVAL BETWEEN ONSET AND DEATH Sudden

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) General Arteriosclerosis

unknown

(c) with history of Chronic myocardial

unknown

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

none

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

none

none

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS

PRIMARY ☐ OR CONTRIBUTING ☐

PLACE (Home, farm, factory, street, office bldg., etc.)

OF INJURY none

(CITY OR TOWN)

(COUNTY)

(STATE)

CAUSE OF DEATH Natural Cause

TIME (Month) (Day) (Year) (Hour)

INJURY OCCURRED

While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?

Suddenly fell dead from Chair 7:30 AM

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

4-14-51

Th L. Moore

Th L. Moore

Waldorf Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

BUREAU V. S.
1951

RECEIVED

COPY SENT TO LOCAL REGISTRATION UNIT
DATE 12-16-57

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH- COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>PRINCE GEORGE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>SEAT PLEASANT</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>7010 Grieg St, Seat Pleasant, Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Residence</u>		STREET ADDRESS (If rural, give location) <u>7010 Grieg St, Seat Pleasant, Md</u>	
3. NAME OF DECEASED (First) <u>DONALD</u> (Middle) <u>LEE</u> (Last) <u>WILSON</u>	4. DATE OF DEATH (Month) <u>4</u> (Day) <u>23</u> (Year) <u>1951</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>Oct. 6, 1950</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	9. AGE last birthday <u>6</u> 1/2 years
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DEWEY L. WILSON</u>		14. MOTHER'S MAIDEN NAME <u>LOUISE C. WILLIAMS</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If year, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>7010 GRIEG ST SEAT PLEASANT, Md.</u>		MOTHER <u>LOUISE WILSON</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause		(a) <u>Respiratory Failure</u>	<u>10 min</u>
Antecedent cause(s)		(b) <u>Atthetosis</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c) <u>Dehydration, malnutrition</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 4-21-1951, to 4-23-1951, that I last saw the deceased alive on 4-21-1951, and that death occurred at 4:30 p.m., from the causes and on the date stated above.

SIGNATURE <u>Griffin B. Shiple, M.D.</u>	(Degree or title)	ADDRESS <u>6916 George Palmer Hwy Seat Pleasant, Md</u>	DATE SIGNED <u>4-23-51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE <u>April 26, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Washington National</u>	LOCATION (City, town, or county) (State) <u>Suitland, Maryland.</u>
DATE REC'D BY LOCAL REG. <u>Apr. 24-51</u>	REGISTRAR'S SIGNATURE <u>Carrie J. Campbell.</u>	24. FUNERAL DIRECTOR <u>W.W. CHAMBERS CO., 517 11th St., S.E.</u>	ADDRESS <u>Wash., D.C.</u>

200060 34540-4

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 25 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

04058

1. PLACE OF DEATH COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>P. 9</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cheverly</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Decatur Heights</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Prince George General Hospital</u>		STREET ADDRESS <u>3902 52nd ST.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Kate</u> (Middle) <u>F. RAZIER</u> (Last) <u>Winn</u>	4. DATE OF DEATH	(Month) <u>April</u> (Day) <u>1</u> (Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>8-10-1863</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	9. AGE last birthday <u>87 yrs.</u>
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Jesse Reech Frazier</u>		14. MOTHER'S, MAIDEN NAME <u>Selma Cowden</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mildred W. Satter Decatur Heights</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) Acute Bacterial Infection
(b) Sensitivity - Gaseous Bacteroides
(c)

INTERVAL BETWEEN ONSET AND DEATH

15 hrsII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED While at Not While at
INJURY m. Work ☐ At work ☐

(CITY OR TOWN) (COUNTY) (STATE)

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 5, 1951, to Sept 1, 1951, that I last saw the deceasedalive on Sept 1, 1951, and that death occurred at 7:05 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL OR CREMATION REMOVAL (Specify) DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

RECEIVED
APR 5 1951
W. R. R. V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH - COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Haward</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Riversdale, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Edwards, Md.</u>	
TOWN <u>Riversdale, Md.</u>		TOWN <u>Edwards, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eugene Island Memorial Hosp.</u>		STREET ADDRESS <u>999 Calverton</u> (If rural, give location) <u>Baltimore Md.</u>	
3. NAME OF DECEASED (Type or Print) <u>Gerald</u> (First) <u>Allen</u> (Middle) <u>Wolf</u> (Last)		4. DATE OF DEATH (Month) <u>4</u> (Day) <u>14</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>4/13/07</u>
9. AGE last birthday <u>43</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Riversdale, Md.</u>	
11. FATHER'S NAME <u>Louis Christian Wolf</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>Mildred Irene Sharpe</u>	
15. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <u>Mother - Edwards, Md.</u>	

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
(a) <u>Congenital atelectasis</u>	
(b) <u>7 mo pregnancy</u>	
(c) <u>Antecedent cause(s)</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	
II. OTHER SIGNIFICANT CONDITIONS	
Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Apr 13, 1951, to Apr 14, 1951, that I last saw the deceased alive on Apr 14, 1951, and that death occurred at 10:2 m., from the causes and on the date stated above.

SIGNATURE L. E. Malin M.D. (Degree or title) ADDRESS Riversdale, Md. DATE SIGNED 4-14-51

23. BURIAL, CREMATION, REBURYAL	DATE THEREOF <u>4/16/51</u>	NAME OF CEMETERY OR CREMATORY <u>Weston Cemetery</u>	LOCATION (City, town, or county) <u>Baltimore Md</u> (State)
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE <u>James Sevey</u>	24. FUNERAL DIRECTOR <u>W.W. Chambers Co. R.R. 204/31 263342</u>	ADDRESS <u>Md</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 17 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

04060

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Penna</u> COUNTY <u>Warren</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Takoma Park</u> LENGTH OF STAY (in this place) <u>9 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Russell</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7305 Inscott Avenue</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>LILLIE</u>	(Middle) <u>MAY</u>	(Last) <u>YOUNG</u>
4. DATE OF DEATH	(Month) <u>April</u>	(Day) <u>22</u>	(Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 11, 1874</u>
9. AGE last birthday <u>77</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Russell, Pa.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>A. Eugene Adams</u>	
14. MOTHER'S MAIDEN NAME <u>Rhoda Briggs</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY No. <u>—</u>		17. INFORMANT AND ADDRESS <u>Greg Gleason, 7305 Inscott Ave, Tak. Pk Md</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Carcinoma Head of Pancreas

INTERVAL BETWEEN ONSET AND DEATH

6 mo.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Carcinoma Ascending Colon6 mo.

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Jaundice, Obstructive6 mo.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov., 1950, to Apr. 22, 1951, that I last saw the deceased alive on April 22, 1951, and that death occurred at 1:00 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>April 24, 1951</u>	<u>Pine Grove Cemetery</u>	<u>Russell, Penna</u>

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>April 24 1951</u>	<u>James Sercy</u>	<u>J. Arthur Walters</u>	<u>254 Carroll St NW DC</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 25 1951
BUREAU V. S.